SEVERE ALLERGY ACTION PLAN
LAKE LOCAL SCHOOL DISTRICT

Student's Name: _____ Date of Birth: _____

Grade: _____ Home Room Teacher: _____

Severe allergy to: _____

Is student Asthmatic? ❑ Yes ❑ No (If yes, student is higher risk for severe reaction)

Has EpiPen or Twinject? ❑ Yes ❑ No If yes, where kept at school? _____

STEP 1: TREATMENT

Symptoms		Give Checked Medication (To be determined by physician authorizing treatment)	
• If a food allergen has been ingested, but no symptoms		❑ Epinephrine	❑ Antihistamine
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	❑ Epinephrine	❑ Antihistamine
• Skin	Hives, itchy rash, swelling of face or extremities	❑ Epinephrine	❑ Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	❑ Epinephrine	❑ Antihistamine
• Throat*	Tightening of throat, hoarseness, hacking cough	❑ Epinephrine	❑ Antihistamine
• Lung*	Shortness of breath, repetitive coughing, wheezing	❑ Epinephrine	❑ Antihistamine
• Heart*	Thready pulse, low BP, fainting, pale, blueness	❑ Epinephrine	❑ Antihistamine
• Other*	_____	❑ Epinephrine	❑ Antihistamine
• If reaction is progressing (several of the above areas affected), give		❑ Epinephrine	❑ Antihistamine

Are potentially life-threatening symptoms. The severity of symptoms can quickly change.

****ALWAYS CALL 911 IF EPINEPHRINE IS ADMINISTERED!****

DOSAGE

Epinephrine: inject intramuscularly *(circle one)* EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15mg
(See reverse side for administration instructions)

Antihistamine: Give _____
Medication/Dose/Route

Other: Give _____
Medication/Dose/Route

STEP 2: EMERGENCY CALLS

1. Call 911. State that all allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Emergency contacts. See attached Emergency Medical Form.

***Even if Parent/Guardian cannot be reached, do not hesitate to medicate and/or call 911.*

Special instructions (to be completed by Physician):

_____ _____ _____
Physician's Signature (required) *Physician's Printed Name* *Date*

_____ _____
Physician's Address *Physician's Phone Number*

I authorize school personnel to implement this management and emergency plan as described above.

_____ _____
Parent/Guardian Signature *Date*