

**Swallow School 2009-2010**  
**Allergy Action Plan/Order Set**

(This form is to be filled out by student's practitioner, only if student has severe allergy needing emergency medication)

Student's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_

Allergy To: \_\_\_\_\_

Teacher: \_\_\_\_\_ Asthmatic Yes  No  \* If yes, higher risk for severe reaction

**STEP 1: TREATMENT**

**Symptoms:**

**Give Checked Medication:**

(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 the 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 blood pressure, fainting, pale, blueness . . . .  Epinephrine  Antihistamine
- Other† \_\_\_\_\_ . . . . .  Epinephrine  Antihistamine
- If reaction is progressing (several of the above areas affected), give . . . . .  Epinephrine  Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

**DOSAGE**

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

**Antihistamine:** give \_\_\_\_\_  
medication/dose/route

**Other:** \_\_\_\_\_  
medication/dose/route

**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**

**STEP 2: EMERGENCY CALLS**

1. Call 911 (or Rescue Squad: \_\_\_\_\_). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_ at \_\_\_\_\_

3. Parents \_\_\_\_\_ Phone Number(s) \_\_\_\_\_

4. Emergency Contacts:

Name/Relationship	Phone Number(s)
_____	_____
_____	_____

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Required)

This form must be filled out by student's practitioner and accompany the medication ordered to be given.