# Cathy's Nursery School
# ALLERGY / ANAPHYLAXIS ACTION PLAN

Child's Name: ________________________________ DOB: ____________________ Classroom:________________

Health Care Provider: ______________________________ Preferred Hospital : ______________________________

History of Asthma: No Yes- Higher risk for severe reaction

**ALLERGY: (check appropriate) TO BE COMPLETED BY HEATH CARE PROVIDER**

- □ **Foods (list):** ________________________________________________________
- □ **Medications (list):** ___________________________________________________
- □ **Latex: Circle: Type 1** **(anaphylaxis)** **Type IV** **(contact dermatitis)**
- □ **Stinging Insects (list):** ______________________________________________

## *STEP 1: TREATMENT *

| **Symptoms:** | **Give Checked Medication** *To be determined by DR ONLY* | |
|---|---|---|
| • If a food allergen has been ingested, but *no symptoms:* | □ EpiPen | □ Antihistamine |
| • Mouth - Itching, tingling, or swelling of lips, tongue, mouth | □ EpiPen | □ Antihistamine |
| • Skin - Hives, itchy rash, swelling of the face or extremities | □ EpiPen | □ Antihistamine |
| • Gut- Nausea, abdominal cramps, vomiting, diarrhea | □ EpiPen | □ Antihistamine |
| • Throat † Tightening of throat, hoarseness, hacking cough | □ EpiPen | □ Antihistamine |
| • Lung † Shortness of Breath, repetitive coughing, wheezing | □ EpiPen | □ Antihistamine |
| • Heart † Thready pulse, low blood pressure, fainting, pale, blueness | □ EpiPen | □ Antihistamine |
| • Other † ____________________________________________ | □ EpiPen | □ Antihistamine |
| • If reaction is progressing (several of the above areas affected), give | □ EpiPen | □ Antihistamine |

The severity of symptoms can quickly change. **† = POTENTIALLY LIFE-THREATENING**

**DOSAGE:**

**Epinephrine**: Inject into outer thigh □ EpiPen 0.3mg OR □ EpiPen Jr. 0.15mg
Start Date _______________ Stop Date _____________

**Antihistamine**: □ **Benadryl ______mg To be given by mouth only if able to swallow**
Start Date_______________ Stop Date ______________________

**Other**: _______________________________________________________________________________
Medication / dose / route/ date

## *STEP 2: EMERGENCY CALLS*

1. Call 911 (or Rescue Squad: __________________). Preferred hospital___________________________________
   - State that an allergic reaction has been treated, and additional epinephrine may be needed).
2. Parent: Mother: __________________________ Father: __________________________________________
   - Dr. _____________________________ at ______________________________________________
3. Emergency Contact: Name & Relationship Phone Number(s)

a. ________________________________________ 1) __________________________ 2) ____________________
b. ________________________________________ 1) __________________________ 2) ____________________
c. ________________________________________ 1) __________________________ 2) ____________________

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE / CALL 911 OR TAKE TO A MEDICAL FACILITY!!!**

Parent/ Guardian Signature ________________________________________________ Date ____________________________

Doctor's Signature _____________________________________________________ Date ____________________________