CCS | CINCINNATI CHRISTIAN SCHOOLS

Christ-Centered 21st Century Education

ALLERGY ACTION PLAN

Student's Name ____________________________ Date of Birth _______________ Grade ______________

Allergy to: ____

Asthmatic ______ No ________ Yes * *Higher risk for severe reaction

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 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 †	Weak or thread pulse, low BP, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other †	________________________________		
If reaction is progressing (several of the above areas affected) give:		☐ Epinephrine	☐ Antihistamine

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

Dosage

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3mg Twinject® 0.15mg

Antihistamine: give ____

Other: give ____

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

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. ______________________________ Phone Number ___________________________
3. Parent ___________________________ Phone Number(s) _________________________
4. Emergency Contact:

   Name__________________________Relationship_________________Phone Number______________

I give permission for the staff at CCS to have access to this information ___________Yes ___________No

Parent/Guardian Signature ____ Date ________________

Doctor's Signature (required) ____ Date ________________

5/24/16