MEDICAL ACTION PLAN

Attach Current photo of child here.

Student's Name: ______________________ DOB ____________ Teacher: ______________

Allergy to: ____

Asthmatic: Yes* _______ No _______ *Higher risk for severe reaction

STEP 1: TREATMENT

(Must be completed by prescribing physician)

Symptoms:	Give Checked Medication**	
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 above areas affected) give	____ EpiPen	____ Antihistamine

Severity of symptoms can change quickly. ** Potentially Life Threatening Reaction

DOSAGE:
Epinephrine: inject intramuscularly (Circle One) EpiPen EpiPen, Jr. (see reverse side for instructions)

Antihistimine: give ____
Medication/dose/route

Inhaler: give ____
Medication/dose/route

STEP 2: EMERGENCY CALLS

Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.

Contact Treating Physician ______________________ at ______________________
(Physicians Name) (Phone)

Emergency Contacts:

Name/Relationship	Phone Number(s)	
______________________	1) ______________	2) ______________
______________________	1) ______________	2) ______________
______________________	1) ______________	2) ______________

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

Parent/Guardian Signature ______________________ Date ______________

Physician Signature ______________________ Date ______________