SEVERE ALLERGY ACTION PLAN PHYSICIAN/PARENT WRITE OR MARK <u>CLEARLY</u> PLEASE!

NAME:	D.O.B	R	M#
Asthmatic Yes No*Higher risk	for severe reaction		
~STEP 1: TRE	ATMENT~		
SYMPTOMS:	Give Checked Medication**: **(To be determined by Physician authorizing treatment)		
If a food allergen has been ingested, but no sympton	ns _	Epinephrine	Antihistamine
 Mouth Itching, tingling, or swelling of lips, tor Skin Hives, itchy rash, swelling of the face of the Gut Nausea, abdominal cramps, vomiting, Throat Tightening of throat, hoarseness, hack Lung Shortness of breath, repetitive coughing Other If reaction is progressing (several of the above a specific property) DOSAGE Epinephrine: inject intramuscularly (circle one) (see reverse side for instructions) Antihistamine: give Medication/do 	or extremities diarrhea ing cough ng, wheezing reas affected) EpiPen 0.30Mg	_Epinephrine _Epinephrine _Epinephrine _Epinephrine _Epinephrine _Epinephrine _Epinephrine _Epinephrine	AntihistamineAntihistamineAntihistamineAntihistamineAntihistamineAntihistamineAntihistamine
Other			
Medication/do	ose/route		
IMPORTANT: Asthma inhalers and/or antihistamines cannot b	e depended on to repla	ce epinephrine in a	naphylaxis.
~STEP 2.: EMERGEN 1. Call 911 State that an allergic reaction has been 2. Dr	treated, and additional phone #: Phone # Phone #	cell	
Parent/guardian's Signature	Date		
DOCTOR'S Signature Required		Date Fax# 482-2006	
Keallitea		r 9 x # 4 X /	Z-ZUUD