Billings Catholic Schools
Faith, Family Spirit, Academic Excellence

ALLERGY ACTION PLAN

PLACE CHILD'S PICTURE HERE

Student Name:_____ DOB:_____ Teacher: _____

ALLERGY TO: _____

Asthmatic ☐ YES *Higher risk for severe reaction ☐ NO

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 ❁	Weakness, thread 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

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

DOSAGE

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

Antihistamine: give _____
Medication/dose/route

Other: give _____
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. Doctor: _____ Phone number: _____
3. Parent: _____ Phone number(S): _____
4. *Emergency Contacts:*
   Name/relationship: _____ Phone number(S): _____

   Name/relationship: _____ Phone number(S): _____

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

Doctor's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____