

TRSNS EMERGENCY ACTION PLAN

School Year 20__ - 20__

Student's Name: _____

D.O.B. _____

ALLERGIC TO: _____

► TREATMENT ◀

Symptoms: Please circle below all that apply to the above listed child	Give Checked Medication**: ** (to be determined by physician authorizing treatment)	
■ If a food allergen has been ingested, but <i>no symptoms</i> :	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 thready 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

► DOSAGE ◀

Antihistamine: medication: _____ dosage: _____

If condition does not improve within _____ minutes or seems to worsen, follow steps for major reaction.

Epinephrine: (inject intramuscularly) **EpiPen** **EpiPen Jr.**

If rescue squad has not arrived within 15 minutes, should child be injected a second time with an EpiPen?
Yes No

Other: medication: _____ dosage: _____

Doctor's Signature: _____ **Date:** _____

► EMERGENCY CALLS ◀

****CALL 911**

MOTHER: _____ **FATHER:** _____

Phone Number(s) _____ Phone Number(s) _____

EMERGENCY CONTACT: _____ Phone Number _____

Dr. (Name & Phone Number Allergist): _____

Dr. (Name & Phone Number Pediatrician): _____

My child has required the use of an EpiPen _____ times, most recently on _____.
The EpiPen was necessary because he/she exhibited the following symptoms:
_____.

The symptoms were caused by (food, bee sting, etc.): _____.

Parent/Guardian's Signature: _____ **Date:** _____