Saint David's School
12 East 89th Street • New York, NY 10128 • 212.369.0058

2008-2009 ALLERGY ACTION PLAN

Student's Name ________________________________ **Grade** __________ **Date of Birth** ____________

Allergy to:____________________________________

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

TREATMENT

Symptoms: — **Give Checked Medication** **

- If a food allergen has been ingested (or insect sting), but no Symptoms are present: ☐ **EpiPen** ☐ **Antihistamine**
- **Mouth** Itching, tingling, or swelling of lips, tongue, mouth ☐ **EpiPen** ☐ **Antihistamine**
- **Skin** Hives, swelling on face or extremities, itchy rash ☐ **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 ☐ **EpiPen** ☐ **Antihistamine**
- **Other** * ________________________________ ☐ **EpiPen** ☐ **Antihistamine**

*Potentially life-threatening

** To be determined by physician

Medications:

Medication	Dose	Form	Route
Epinephrine	☐ EpiPen ☐ EpiPen Jr	Auto injector	Inject intramuscularly in the outer thigh
Antihistamine: ☐ Diphenhydramine HCL	☐ 12.5 mg ☐ 25 mg ☐ 50 mg ☐ Other Dose ____________	Liquid Fast-melt Tablet Thin Strips	PO
Other Medication:			

EMERGENCY CALLS

1. **If EpiPen is given, call 911. State a severe allergic reaction and request additional epinephrine.**
   ***Give a new EpiPen every 15 minutes until ambulance arrives.**

2. Call parent/guardian or emergency contact and healthcare provider.

3. Emergency Contacts: (only called in the event that the parent/guardian cannot be reached)

Name ________________________________ Ph: ____________________ Ph: ____________________
Name ________________________________ Ph: ____________________ Ph: ____________________

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

*This order form will be in effect for the 2008-2009 school year only. **These orders will **not be valid** without the **Provider's Office Stamp** below. Stamp should contain name, address, phone and license #.*

______________________ ________ ______________________ ________
Parent/Guardian's Signature **Date** **Physician Signature (required)** **Date**

****Office Stamp:**