ALLERGY ACTION PLAN

Kent County Public Schools

Student Name: _____ DOB: _____ Teacher: _____

ALLERGIES: _____

*Asthmatic: ☐ Yes ☐ No

Symptoms	**Give checked medication**
If ***exposed to an allergen***, but experiencing no symptoms.	☐ Epinephrine ☐ Antihistamine
If a ***food*** allergen has been ingested, but experiencing no symptoms.	☐ Epinephrine ☐ Antihistamine
Mouth: Itching, tingling, or swelling of lips, tongue, or mouth	☐ Epinephrine ☐ Antihistamine
Skin: Hives, itching, swelling of face or any body part	☐ Epinephrine ☐ Antihistamine
GI: Nausea, vomiting, diarrhea, abdominal cramps	☐ Epinephrine ☐ Antihistamine
Throat: Tightening of throat, hoarseness, cough, voice change	☐ Epinephrine ☐ Antihistamine
Lung: Shortness of breath, wheezing, repetitive coughing	☐ Epinephrine ☐ Antihistamine
Heart: Weak or thready pulse, low BP, fainting, pale, cyanotic	☐ Epinephrine ☐ Antihistamine
Other:	☐ Epinephrine ☐ Antihistamine
*If reaction is progressing (several of the above areas are affected)	☐ Epinephrine ☐ Antihistamine

Medication/Dosage/Route:

Epinephrine: Inject intramuscularly ☐ EpiPen® ☐ EpiPen® Jr
Antihistamine: Give _____ Dose: _____
Other:

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EMERGENCY CONTACT INFORMATION

If Epinephrine was administered, CALL 911! (The student must be transported to a hospital for continued medical care.)

Physician Name:	
Parent/Guardian Name:	
Emergency Contact Name:	

*If the parent/guardian cannot be reached, do not hesitate to medicate and/or take the student to the hospital.

_____ _____

Physician Signature Date

_____ _____

School Nurse Signature Date

I understand and agree that the information on this form will be shared with appropriate school staff.

_____ _____

Parent/Guardian Signature Date