

BBA ALLERGY ACTION PLAN

STUDENT'S NAME _____ D.O.B. _____

CLASS: _____ TEACHER: _____

ALLERGY TO: _____

ASTHMATIC? **YES*** _____ **No** _____

***HIGHER RISK FOR SEVERE REACTION**

PARENT/GUARDIAN NAME:

PARENT/GUARDIAN SIGNATURE: _____

DATE _____

Symptoms:

- | | | |
|--|--------------------------------------|--|
| • <i>No symptoms</i> , but known allergen was ingested: | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Mouth Itching, tingling, or swelling of lips, tongue, mouth | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Skin Hives, itchy rash, swelling of the face or extremities | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Gut Nausea, abdominal cramps, vomiting, diarrhea | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Throat** Tightening of throat, hoarseness, hacking cough | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Lung** Shortness of breath, repetitive coughing, wheezing | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Heart** Thready pulse, low blood pressure, fainting, pale, blueness | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Other** _____ | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| • Reaction is progressing (several of above areas affected), give | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

**Potentially life threatening. Severity of symptoms can change quickly.

Dosage

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15mg

Antihistamine: _____

Instructions _____

Other: _____ Instructions _____