Place Student's Picture Here

Greeneville City Schools
Allergy Action Plan
School Year: ______________________________

Student's Name: ____________________________ School: ___________________ Date of Birth: ______________

Allergy to: ____
Does the student have asthma? __________ Yes __________ No

Step 1: Treatment

		Give Checked Medication (Medications to be determined by physician authorizing treatment)		
Symptoms		*Epinephrine*	*Antihistamine*	*Inhaler*
If allergen has been ingested, but no symptoms		□	□	□
Mouth	Itching, tingling or swelling of lips, tongue, mouth	□	□	□
Skin	Hives, itchy rash, swelling of the face or extremities	□	□	□
Gut	Nausea, abdominal cramps, vomiting, diarrhea	□	□	□
Throat*	Tightening of throat, hoarseness, hacking cough	□	□	□
Lung*	Shortness of Breath, repetitive coughing, wheezing	□	□	□
Heart*	Thready pulse, low blood pressure, fainting, blueness, pale	□	□	□
Other*		□	□	□

*Potentially life-threatening

Dosage:

Epinephrine: inject in outer thigh □ Epi-Pen □ Epi-Pen Jr.

Should a second dose of epinephrine be given? □ Yes □ No
Instructions for 2nd dose of epinephrine: ____

Antihistamine: Give ____
(Medication/Dose/Route)

Inhaler: Give ____
(Medication/Dose/Route)

Step 2: Emergency Calls

Call 911—provide information regarding emergency and location of student.
Call Emergency Contacts:

Name/ Relationship	Cell Phone	Work Phone	Home Phone

****Even if emergency contacts cannot be reached, 911 should transport student to hospital for follow-up after the administration of epinephrine.**

Parent/Guardian Signature: ______________________________________ Date: ________________

Healthcare Provider Signature (Required): ________________________________ Date: ________________