Mountain Lakes High School
Mountain Lakes, New Jersey 07046

EMERGENCY ALLERGY ACTION PLAN

Student:_____ Date of Birth:_____ Grade:_____

ALLERGY / Anaphylaxis to:_____

Asthmatic: Yes_____* No_____ *High risk for severe reaction

STEP 1: TREATMENT

Symptoms: Recognize symptoms and assess	Administer Medication Circled** ** (To be determined by physician authorizing treatment)	
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, paleness, blueness	Epinephrine	Antihistamine
General: Anxiety, panic, feeling of impending doom	Epinephrine	Antihistamine

The severity of symptoms can quickly change. **All above symptoms can potentially progress to a life-threatening situation. Student may experience multiple symptoms from one or more body areas.

DOSAGE
Epinephrine: inject intramuscularly (circle one)
EPIPEN 0.3mg EPIPEN Jr 0.15mg Twinject 0.3mg Twinject 0.15mg

Antihistamine: administer_____
medication/dose/route

Other: administer_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Student has been instructed and is capable of self-administration.
Student may carry and self-administer one single dose of Antihistamine: Yes_____ No_____
Student may carry and self-administer epinephrine auto-injector: Yes_____ No_____

STEP 2: EMERGENCY CALLS

Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.

Dr. _____ Phone Number:_____

Parent_____ Phone Number:_____

Emergency Contact_____ Phone Number:_____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

_____ _____ _____ _____
Parent's Signature Date Physician's Signature Date