Physician/Parent Authorization for Anaphylaxis Management
Allergy Action Plan
*This form is to be renewed at the beginning of each school year.

Students Name:	**Date:**
Teacher/Grade:	**DOB:**
ALLERGIC TO:	

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

TO BE COMPLETED BY THE PHYSICIAN
The parent/guardian of the above named student has notified the school that this student has a potentially life-threatening allergy and will require an Epipen at school, in the event of an emergency. Please complete this form based on your records and knowledge of this student and sign in the space provided.

♦STEP 1: TREATMENT♦

Symptoms:	**Give Checked Medication**:** **(to be determined by provider authorizing treatment)	
If food allergen has been ingested or allergen has been contacted, but *no symptoms:*	☐ Epinephrine	☐ Antihistamine
Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin Hives, itcl.y 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† Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other†	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected),	☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE
Epinephrine: inject intramuscularly (circle one)
EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
(see reverse side for instructions)
Antihistamine: give______________________________
Medication/dose/route
Other: give______________________________
Medication/dose/route

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

Student Name:

Step 2: EMERGENCY CALLS

1. Call 911 (or Emergency Medical Services__________________). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Provider:

_______________________________________at___________________________________

3. Emergency contacts:
   a.______________________________1)__________________2)______________
   b.______________________________1)__________________2)______________
   c.______________________________1)__________________2)______________

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

Physician's Signature:_______________________________________Date______________

Physician's Name:__________________________________Phone____________________

Address:_______________________________________ Fax:_______________________

TO BE COMPLETED BY PARENT

I, The undersigned, the parent/guardian of ______________________________request that an Epipen be administered to my child, as prescribed by the physician.