Nelsonville – York City School District
Allergy Action Plan

Student Name: _____ DOB: _____ Age: _____
Home Room Teacher: _____ Grade: _____
Parent/Guardian: _____ Phone (C): _____
Phone (H): _____ Phone (W): _____
Health Care Provider/Physician Treating Student for Allergy: _____
Phone # _____
Other Health Care Provider: _____
Phone: _____

Allergy To: _____

Asthma ☐ **Yes*** ☐ **No** ***Higher risk for severe reaction**
Additional health problems besides anaphylaxis: _____
_____
Medications: _____
_____

STEP 1 TREATMENT

Symptoms:	**Provide Care as Directed Below: Per Physician** (Prescribed Medication Authorization Form Must be on File)		
•If a food allergen has been ingested, but***, no symptoms***:	☐Epinephrine	☐Antihistamine	☐Other/No Care needed at this time
•Mouth- Itching, tingling, or swelling of lips, tongue, mouth	☐Epinephrine	☐Antihistamine	☐Other/No Care needed at this time
•Skin- Hives, itchy rash, swelling of the face or extremities	☐Epinephrine	☐Antihistamine	☐Other/No Care needed at this time
•Gut- Nausea, abdominal cramps, vomiting, diarrhea	☐Epinephrine	☐Antihistamine	☐Other/No Care needed at this time
•Throat- Tightening of throat, hoarseness, hacking cough	☐Epinephrine	☐Antihistamine	☐Other/No Care needed at this time
•Lung- Shortness of breath, repetitive coughing, wheezing	☐Epinephrine	☐Antihistamine	☐Other/No Care needed at this time
•Heart- decrease in pulse, low blood pressure, fainting, pale, blueness	☐Epinephrine	☐Antihistamine	☐Other/No Care needed at this time
•Other- _____ _____	☐Epinephrine	☐Antihistamine	☐Other/No Care needed at this time

IMPORTANT: ASTHMA INHALERS AND/OR ANTIHISTAMINES CAN'T BE DEPENDED ON IN ANAPHYLAXIS.

STEP 2 EMERGENCY CALLS

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed
2. Dr. _____ at _____

Comments/Special Instructions *(regarding school activities, sports, trips, etc.)*
_____
_____

Physician Signature: _____ Date: _____

☑ I authorize the licensed healthcare professional to talk with the prescriber to clarify Allergy Action Plan.

Parent/Guardian Signature: _____ Date: _____

Please attach an extra sheet of paper for additional charting space

Adopted from Food Safe Schools. 5/2012