Allergy Action Plan

For: _____

Allergic to:*	Food
	Insects
	Latex
	Miscellaneous
Asthmatic:*	Yes (High risk for severe reaction)
	No

Action for Minor Reaction*

If only symptom(s) are: ,
give (*Medication/Dose/Route*)

Epi Pen (0.3 mg) (Parent must supply Epi-Pen)
Epi Pen Jr. (0.15 mg) (Parent must supply Epi-Pen)
Twinject (0.3 mg) (Parent must supply Twinject)
Twinject Jr. (0.15 mg) (Parent must supply Twinject)
Benadryl (appropriate dose calculated based on weight)
Other

Then call: Mother at Father at

Action for Major Reaction*

If ingestion is suspected and/or symptom(s) are: ,
give (*Medication/Dose/Route*)

Epi Pen (0.3 mg) (Parent must supply Epi-Pen)
Epi Pen Jr. (0.15 mg) (Parent must supply Epi-Pen)
Twinject (0.3 mg) (Parent must supply Twinject)
Twinject Jr. (0.15 mg) (Parent must supply Twinject)
Benadryl (appropriate dose calculated based on weight)

Other

Then call: Mother at

Father
at

I give permission to the school nurse, trained allergy personnel, and other designated staff members to perform and carry out the tasks as outlined by _____ Allergy Action Plan. I also consent to the release of the information contained in this Allergy Action Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.