Place Student's Picture Here

Greeneville City Schools
Allergy Action Plan

Student's Name: _____ School: _____ Date of Birth: _____

Allergy to: _____
Does the student have asthma? _____ Yes _____ No

Step 1: Treatment

Symptoms		**Give Checked Medication** (Medications to be determined by physician authorizing treatment)	
		Epinephrine	*Antihistamine*
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 subcutaneously □ Epi-Pen □ Epi-Pen Jr. □ TwinJect 0.3 □ TwinJect 0.15

Should a second dose of epinephrine be given? □ Yes □ No

Instructions for 2nd dose of epinephrine: _____

Antihistamine: Give _____
(Medication/Dose/Route)

Other: 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: _____