MJCCA MARCUS JCC of ATLANTA **CLUB J**

2023-2024 Allergy Action Plan

Child's Last Name	Child's First Name	Date of Birth
Parent/Guardian Last Name	Parent/Guardian First Name	
Allergy to	Asthmatic ☐Yes (Higher risk) ☐ No	

STEP 1: TREATMENT

SYMPTOMS	**GIVE CHECKED MEDICATION**	
○ If a food allergen has been ingested, but *no symptoms*:	☐Epinephrine	☐Antihistamine
○ 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† - *Thready pulse, low blood pressure, fainting, pale, blueness*	☐ Epinephrine	☐ Antihistamine
○ Other† ____	☐Epinephrine	☐Antihistamine
○ If reaction is progressing (several of the above areas affected), give	☐Epinephrine	☐ Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly ☐EpiPen® ☐EpiPen® Jr. ☐Twinject™ 0.3 mg ☐Twinject™ 0.15 mg

Antihistamine: give____
medication/dose/route

Other: give____
medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: ________________________). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____________________________________ at _____________________________________

3. Emergency contacts:

Last Name ________________________________ First Name ___________________________________
Home # ____________________ Cell #_____________________Relationship ____________________

Last Name ________________________________ First Name ___________________________________
Home # ____________________ Cell #_____________________Relationship ____________________

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

Parent/Guardian Signature ____ Date_________

Doctor's Signature ____ Date__________