CLUB J

2018-2019 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_____

****PLEASE INITIAL HERE IF THIS IS NOT APPLICABLE TO YOUR CHILD: _____**

MJCCA Club J AFTER-SCHOOL PROGRAM