ADOLPH & ROSE LEVIS JEWISH COMMUNITY CENTER
Betty + Marvin Zale Early Childhood Learning Center

Allergy Action Plan

Place Child's Picture Here

Student's Name:_____D.O.B:_____Teacher:_____

Allergy To:_____

Asthmatic: Yes* ☐ No ☐ *Higher risk for severe reaction

●STEP 1: TREATMENT●

Symptoms:	**Give Checked Medication**:** (**To be determined by physician authorizing treatment)	
• 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†: Weak or 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

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

●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. _____ Phone Number: _____

3. Parent_____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship	Phone Number(s)
a. _____	1.)_____ 2.) _____
b. _____	1.)_____ 2.) _____

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

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

Procedures and/or
Restrictions:_____
_____
_____

I understand:
- Medication authorization is valid for one year.
- Medication must be in original container and labeled to match directions for use given above.
- I will supply medication to be kept in the classroom and office as well as additional supplies for other programs, if necessary.
- Medication may not be sent to or from school in child's backpack or lunchbox.
- A log will be kept at school in order to record administration of medication.
- Emergency Personnel (911) will be called if Adolph and Rose Levis Jewish Community Center staff deems it necessary. All efforts will be made to contact me if an emergency arises.

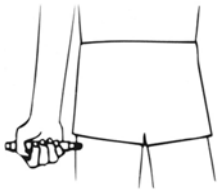
I give permission for information regarding diagnosis and/or medication administration to be shared with appropriate staff in order to ensure my child's health and safety.

Parent or Guardian Signature:_____ Date:_____

EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**

- **Hold black tip near outer thigh (always apply to thigh).**



- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

- **Once EpiPen® or Twinject® is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.**

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

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MEETING TO REVIEW ALLERGY PLAN

Date	Name	Title	Signature