Severe Allergy Action Plan and Medication Authorization

Date: [Insert Date]

1. Student/Individual Information

Name: [Insert Name]

Date of Birth: [Insert DOB]

Allergy to: [Insert Allergen, e.g., Peanuts, Bee Stings]

2. Emergency Contact Information

Primary Contact: [Name] - [Phone Number]

Secondary Contact: [Name] - [Phone Number]

Preferred Hospital: [Insert Hospital Name]

3. Symptoms and Action Plan

If a student has been exposed but has NO symptoms:
[ ] Monitor closely. [ ] Administer Epinephrine immediately. [ ] Administer Antihistamine.

Mild Symptoms (Itchy mouth, few hives, mild nausea):
Action: [Insert Instruction, e.g., Give Antihistamine and stay with student]

Severe Symptoms (Shortness of breath, wheezing, swelling of tongue/lips, weak pulse, fainting):
Action: ADMINISTER EPINEPHRINE IMMEDIATELY AND CALL 911.

4. Medication Authorization

The following medications are authorized for administration:

- **Epinephrine Brand/Dose:** [e.g., EpiPen Jr. 0.15mg]
- **Antihistamine Name/Dose:** [e.g., Benadryl 25mg]
- **Other Medication:** [Insert if applicable]

5. Self-Administration

[ ] Student is permitted to carry and self-administer their inhaler/epinephrine.
[ ] Student is NOT permitted to self-administer; medication must be kept in the office.

6. Physician and Parent Signatures

Physician Name: _____
Physician Signature: _____ Date: _____

Parent/Guardian Name: _____
Parent/Guardian Signature: _____ Date: _____