LAMAR CONSOLIDATED INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

LIFE-THREATENING ALLERGY ACTION PLAN

STUDENT PHOTO

STUDENT NAME : (Last)_____ (First)_____

D.O.B:_____**Grade**:_____

ALLERGY/ALLERGIES:_____

_____

ASTHMATIC: Yes_____ No_____ **(Higher risk for severe reaction if asthmatic)**

TREATMENT

For these **SYMPTOMS:**	Give these **MEDICATIONS:**	
For **EXPOSURE with NO symptoms**	☐ ANTIHISTAMINE	☐ EPINEPHERINE
ORAL/MOUTH: Itching,Tingling, Swelling of Lips, Tongue or Mouth	☐ ANTIHISTAMINE	☐ EPINEPHERINE
THROAT: Tightening of throat, hoarseness, hacking cough	☐ ANTIHISTAMINE	☐ EPINEPHERINE
LUNG: Shortness of breath, Continual Cough, Wheezing	☐ ANTIHISTAMINE	☐ EPINEPHERINE
SKIN: Itchy rash, Hives, Swelling of face or extremities	☐ ANTIHISTAMINE	☐ EPINEPHERINE
GI: Nausea, Abdominal cramps, Vomiting, Diarrhea	☐ ANTIHISTAMINE	☐ EPINEPHERINE
HEART: Weak/thready pulse, low B/P, Dizziness/Fainting, Pale/Blue	☐ ANTIHISTAMINE	☐ EPINEPHERINE
OTHER: Please specify	☐ ANTIHISTAMINE	☐ EPINEPHERINE
If Reaction is Progressing In Several Above Areas	☐ ANTIHISTAMINE	☐ EPINEPHERINE

DOSAGE

Epinephrine:
Inject intramuscularly (select one): EpiPen®_____ EpiPen® Jr._____

Twinject® 0.30mg _____ TwinJect 0.15mg. _____ Other: Please Specify: _____

Antihistamine: Medication:_____Dose: _____
Route_____ Frequency: _____

Other: Medication:_____ Dose: _____
Route: _____ Frequency: _____

PLEASE SEE OTHER SIDE-PARENT AND PHYSICIAN SIGNATURE REQUIRED

EMERGENCY INFORMATION

- **Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed**

- **PARENT/GUARDIANS/EMERGENCY CONTACTS**:

1. Name: _____ Relationship: _____
   Home: _____ Work: _____
   Other: _____

2. Name: _____ Relationship: _____
   Home: _____ Work: _____
   Other: _____

3. Name: _____ Relationship: _____
   Home: _____ Work: _____
   Other: _____

4. Name: _____ Relationship: _____
   Home: _____ Work: _____
   Other: _____

- **PHYSICIAN**: Name (Please print)_____

  Office Number:_____ Emergency Number:_____

ADDITIONAL INFORMATION IF NEEDED: _____
_____
_____
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_____
_____
_____
_____

PARENT/GUARDIAN SIGNATURE: _____ Date:_____

PHYSICIAN SIGNATURE: _____ Date:_____