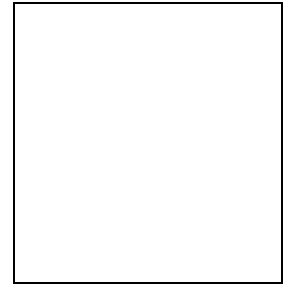


LAMAR CONSOLIDATED INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

**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	<input type="checkbox"/> ANTIHISTAMINE <input type="checkbox"/> EPINEPHERINE
ORAL/MOUTH: Itching, Tingling, Swelling of Lips, Tongue or Mouth	<input type="checkbox"/> ANTIHISTAMINE <input type="checkbox"/> EPINEPHERINE
THROAT: Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> ANTIHISTAMINE <input type="checkbox"/> EPINEPHERINE
LUNG: Shortness of breath, Continual Cough, Wheezing	<input type="checkbox"/> ANTIHISTAMINE <input type="checkbox"/> EPINEPHERINE
SKIN: Itchy rash, Hives, Swelling of face or extremities	<input type="checkbox"/> ANTIHISTAMINE <input type="checkbox"/> EPINEPHERINE
GI: Nausea, Abdominal cramps, Vomiting, Diarrhea	<input type="checkbox"/> ANTIHISTAMINE <input type="checkbox"/> EPINEPHERINE
HEART: Weak/thready pulse, low B/P, Dizziness/Fainting, Pale/Blue	<input type="checkbox"/> ANTIHISTAMINE <input type="checkbox"/> EPINEPHERINE
OTHER: Please specify	<input type="checkbox"/> ANTIHISTAMINE <input type="checkbox"/> EPINEPHERINE
If Reaction is Progressing In Several Above Areas	<input type="checkbox"/> ANTIHISTAMINE <input type="checkbox"/> 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: _____

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____

PHYSICIAN SIGNATURE: _____ **Date:** _____