Lighthouse Montessori School

Allergy / Medical Action Plan

Child's Name: _____ DOB: _____

Allergy to: _____ Asthmatic:: Yes ___ No: ___

Other Medical Condition: _____

STEP 1 - TREATMENT

SYMPTOMS:	CIRCLE MEDICATION TO BE GIVEN:	
1. If a food allergen has been ingested, but no symptoms:	1. ___epinephrine	___ Antihistamine
2. Mouth - Itching, tingling, or swelling of lips, tongue, mouth	2. ___epinephrine	___ Antihistamine
3. Skin - Hives, itchy rash, swelling of the face or extremities	3. ___epinephrine	___ Antihistamine
4. Gut - Nausea, abdominal cramps, vomiting, diarrhea	4. ___epinephrine	___ Antihistamine
5. Throat- Tightening of the throat, hoarseness, hacking cough	5. ___epinephrine	___ Antihistamine
6. Lung - Shortness of breath, repetitive coughing, wheezing	6. ___epinephrine	___ Antihistamine
7. Heart - Thready pulse, fainting, pale, blueness	7. ___epinephrine	___ Antihistamine
8. Other symptoms: _____	8. ___ Medication: _____	

9. Additional Note _____

DOSAGE

1. Epinephrine: inject intramuscularly (circle one):

EpiPen_____ EpiPen Jr._____ Other: _____

Other Medication:_____ Dosage: _____

2.Antihistamine: Medication: _____Dosage: _____

3. Other Medication:_____ Dosage: _____

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

STEP 2 - EMERGENCY CALLS

1. Call 9-1-1. State that an allergic reaction has been treated, additional epinephrine may be needed.

2. Call Parents: Primary Contact Parent: Name _____ Ph# _____

Secondary Contact Parent: Name _____ Ph# _____

3. **EVEN IF PARENTS CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE THE CHILD TO A MEDICAL FACILITY.**

Parent Signature: _____Date: _____

Doctor's Signature _____ Date: _____