BULLIS ALLERGY ACTION PLAN

To be completed by the Physician—if applicable

Place Student's Picture Here

Camper: _____ **Date of birth:** _____

Allergy Action Plan

Reactive to the following: _____

Check one, please:

☐ Give epinephrine and recommended oral antihistamine dose immediately if exposed to allergen, even if no symptoms are noted

☐ Give epinephrine and recommended oral antihistamine dose immediately, for ANY symptoms if exposed.

Epinephrine dose ☐ **0.15 mg** ☐ **0.3 mg** **Student will carry epinephrine** ☐ **YES** ☐ **NO**

☐ Exposure to this allergen(s) does not require epinephrine. Treat per Mild Symptoms protocol below with the recommended oral antihistamine, if needed.

Oral Antihistamine (type and dosage, ex: Benadryl 25mg): _____

Any SEVERE SYMPTOMS after suspected or known ingestion.

One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
SKIN: Hives, itch rash, swelling (e.g. eyes and lips)
GUT: Vomiting crampy pain

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1. **INJECT EPINEPHRINE IMMEDIATELY**
   - **Note time epinephrine was administered.**
2. Call 911, Alert School Nurse or ATC if on campus
   - Advise rescue squad epinephrine has been given. Request ambulance with epinephrine
3. Begin monitoring
   - A second dose of epinephrine can be given 15 minutes or more after the first symptoms persist or recur
4. Give additional medications
   - Antihistamine such as Benadryl
   - Inhaler (bronchodilator) if asthma

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

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1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent.
3. If symptoms progress, **USE EPINEPHRINE**
4. Monitor

PARENT CONTACT INFORMATION

Parent 1: _____ **Parent 2:** _____

Home #: _____ **Home #:** _____

Work #: _____ **Work #:** _____

Cell #: _____ **Cell #:** _____

Other Emergency Contact: _____ _____

Name **Contact Number**

_____ _____

Physician Signature **Date** **Affix Stamp Here**