المدرسة العالمية الأمريكية
UNIVERSAL AMERICAN SCHOOL

Al-Futtaim Education Foundation

ALLERGY ACTION PLAN

Student's name: ______________________________ D.O.B______________ Grade Level: ____
Allergy to: ____
Asthmatic ___YES ____ NO

STEP 1: TREATMENT
(To be determined by Physician authorizing treatment)

Symptoms	**Give checked medications**	
1. If a food allergen has been ingested but no symptoms	___ Epi-pen	___ Antihistamine
2. Mouth - itching, tingling or swelling of lips, tongue and mouth	___ Epi-pen	___ Antihistamine
3. Skin - hives, itchy rashes, swelling of the face /extremities	___ Epi-pen	___ Antihistamine
4. Gut – Nausea, vomiting, abdominal cramps, and diarrhea	___ Epi-pen	___ Antihistamine
5. Throat – Tightening of throat, hoarseness, hacking cough	___ Epi-pen	___ Antihistamine
6. Lung – Shortness of breath, repetitive coughing, wheezing	___ Epi-pen	___ Antihistamine
7. Heart – Thready pulse, low blood pressure, fainting, pale	___ Epi-pen	___Antihistamine
8. Others – Please specify: ____________________________	___Epi-pen	___ Antihistamine
9. If reaction is progressing (several of the above areas affected)	___Epi-pen	___Antihistamine

The severity of symptoms can quickly change. + Potentially life threatening.

DOSAGE:

Epinephrine: Inject intramuscularly ____ Epipen Adult ____Epipen Jr.
Antihistamine: (medication/dose/route): ____

STEP 2: EMERGENCY CALLS

1. **Call 998**. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Emergency contacts:

Name	Relationship	Phone numbers
____________________	_____________________	_________________
____________________	_____________________	_________________
____________________	_____________________	_________________

Even if parent /guardian can't be reached, don't hesitate to medicate or take the child to medical facility.

Signature of Parent/Guardian___________________________ Date _______________

Doctor's Signature ____________________________________ Date _______________