LATEX ALLERGY ACTION PLAN

Place Child's Picture Here

Student's Name:_____D.O.B:_____Teacher:_____

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ * Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:		**Give Checked Medication**:** **(To be determined by physician authorizing treatment)
• Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐Epinephrine ☐Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	☐Epinephrine ☐Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐Epinephrine ☐Antihistamine
• Throat†	Tightening of throat, hoarseness, hacking cough	☐Epinephrine ☐Antihistamine
• Lung†	Shortness of breath, repetitive coughing, wheezing	☐Epinephrine ☐Antihistamine
• Heart†	Weak or thread pulse, low blood pressure, fainting, pale, blueness	☐Epinephrine ☐Antihistamine
• Other†		☐Epinephrine ☐Antihistamine
• If reaction is progressing (several of the above areas affected), give:		☐Epinephrine ☐Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen Jr. ® Twinject® 0.3 mg Twinject® 0.15mg (see reverse side for instructions)

Antihistamine: give_____
Medication/dose/route

Other: give _____
Medication/dose/route

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

STEP 2: EMERGENCY CALLS

Call 911 (or Rescue Squad:_____). State than an allergic reaction has been treated, and additional epinephrine may be needed.

1. Dr. _____Phone Number_____
2. Parent_____Phone Number_____
3. Emergency contacts:
   Name/Relationship Phone Number(s)

a._____ _____ _____

b._____ _____ _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____Date_____

Doctor's Signature (Required)_____Date_____