Anaphylaxis Action Plan

Personal Information

Current Photo

Student Name: _____

Teacher(s) Name: _____

Date of Birth: _____

Parent/Guardian: _____ Day Contact # _____

Emergency Contact: _____ Day Contact # _____

Physician: _____ Contact # _____

Medication/Medic Alert Information

Medic Alert: Yes ☐ No ☐

EpiPen® kept with Student _____ location:_____ exp. _____

EpiPen® kept with Teacher _____ location: _____ exp. _____

EpiPen® kept with Office _____ location: _____ exp. _____

Other : _____

Additional medications (if any): _____

Asthmatic: Yes ☐ No ☐ Additional Info (if any):_____

Previous Anaphylactic Reaction: Yes ☐ No ☐ Additional Info (if any):_____

Anaphylaxis Triggers

☐ Peanuts ☐ Nuts ☐ Milk ☐ Dairy ☐ Eggs ☐ Shellfish ☐ Fish

☐ Food Additives (list): _____

☐ Insect Stings (list): _____

☐ Medications (list): _____

☐ Others / Details (list): _____

Anaphylaxis Symptoms

☐ Swelling (eyes, lips, face, tongue)
☐ Cold, clammy, sweaty skin
☐ Fainting or loss of consciousness
☐ Wheezing, coughing or choking
☐ Dizziness, confusion
☐ Difficulty breathing or swallowing
☐ Flushed face or body
☐ Vomiting
☐ Stomach cramps, nausea, diarrhea
☐ Hives, rash

☐ Others (list): _____

Parent/Guardian Signature: _____ Date: _____

This information will expire on July 1st of each academic year or when prescription expires – medication shall be removed from the school at that time.