IMA | Indiana Montessori Academy

I M A child creating our future

Allergy Action Plan

Place Child's Picture Here

CHILD INFORMATION

Last | First | Middle | Date of Birth (mo/day/year)

DIRECTRESS

ALLERGY TO:

ASTHMATIC*

☐ YES* ☐ NO

*Higher risk to allergic reaction

DIETARY RESTRICTIONS

TREATMENT

SYMPTOMS:	GIVE CHECKED MEDICATION* (determined by physician authorizing treatment)			
If a food allergen has been ingested, but *no symptoms*:	☐	Epinephrine	☐	Antihistamine
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† Thready pulse, low blood pressure, fainting, feeling lightheadedneww, pale, blueness	☐	Epinephrine	☐	Antihistamine
Other†	☐	Epinephrine	☐	Antihistamine
If reaction is progressing (several of the above areas affected), give	☐	Epinephrine	☐	Antihistamine

DOSAGE:

Epinephrine: inject intramuscularly (check one) ☐ EpiPen® ☐ EpiPen® Jr. ☐ TwinjectTM 0.3 mg ☐ TwinjectTM 0.15 mg

Medication Instructions

AUTHORIZATION:

I give permission for a staff member of Indiana Montessori Academy to dispense this medication to the child named above.

Printed Name | Signature | Date

Contact Information Name | Cell Phone | Work Phone | Email Address