School District of Crandon

ALLERGY TREATMENT PLAN

Student Name: _____ **DOB:** _____

School:_____ **Grade:**_____ **Teacher:**_____

Allergy to: _____ **if exposed by being stung, ingesting, inhaling, skin contact** (circle one).

Asthmatic: Yes* or No (* higher risk for severe reaction)

Epinephrine medication: (Circle appropriate)**: EpiPen EpiPen Junior Twinject 0.3 Twinject 0.15 AUVI-Q SYMJEPI Adrenaclick Other:**_____

Antihistamine: Benadryl/Diphenhydramine or Other_____

Dose: _____ **Route of administration:**_____

Time(s) to be given as indicated below: _____

If exposed, but no symptoms	**Antihistamine**	**Epinephrine/call 911**
Mouth (itching, tingling)	**Antihistamine**	**Epinephrine/call 911**
Skin (hives, itchy, rash, swelling)	**Antihistamine**	**Epinephrine/call 911**
Gut (nausea, cramps, diarrhea, vomiting)	**Antihistamine**	**Epinephrine/call 911**
Throat (tightness, hoarseness, hacking cough)	**Antihistamine**	**Epinephrine/call 911**
Lung (shortness of breath, repetitive coughing, wheezing)	**Antihistamine**	**Epinephrine/call 911**
Heart (fainting, pale, blue, weak or thready pulse, low BP)	**Antihistamine**	**Epinephrine/call 911**
Other _____	**Antihistamine**	**Epinephrine/call 911**

Any additional directions: _____

Date of discontinuation:_____

Explain possible reactions: _____

PHYSICIAN AUTHORIZATION

The physician whose signature follows hereby authorizes the above procedure to be performed during the school day in accordance with the above instructions. I agree to accept communication regarding the administration procedures. It is understood that the medication may be given by non-licensed personnel.

Physician's Signature: _____ Date:_____