WESTFORD PUBLIC SCHOOLS
Allergy Action Plan and Individual Health Care Plan

Place Photo Here

Student's Name: _____ DOB: _____ Grade: ____ Bus #: _____

ALLERGY TO: _____ Documented: _____ Date: _____ Asthma: Yes/No

STEP 1: TREATMENT (TO BE COMPLETED BY M.D.)

Student's Symptoms:

❑	Mouth	Itching, tingling, or swelling of lips, tongue, mouth
❑	Skin	Hives, itchy rash, swelling of the face or extremities
❑	Gut	Nausea, abdominal cramps, vomiting, diarrhea
❑	Throat	Tightening of throat, hoarseness, hacking cough
❑	Lung	Shortness of breath, repetitive coughing, wheezing
❑	Heart	Weak or thready pulse, low blood pressure, fainting, pale, blueness
❑	Other	_____

STEP 2: DOSAGE (TO BE COMPLETED BY M.D.)

- ❑ **Epipen®**
- ❑ **Epipen®Jr.**
- ❑ **Adrenaclick™ 0.3 mg**
- ❑ **Adrenaclick™ 0.15 mg**
- ❑ **Twinjet® 0.3 mg,**
- ❑ **Twinjet® 0.15 mg**

PLEASE NOTE: *The 2nd dose of epinephrine must be administered by a health care provider.*

Doctor's Signature: _____ **Specialty**: _____ **Date**: _____

STEP 3: EMERGENCY CALLS (TO BE COMPLETED BY PARENT/GUARDIAN)
This sheet accompanies your child on every field trip

1. **Call 911: State: "Epipen® has been administered and additional epinephrine may be needed."**

	Home phone	Cell phone	Work phone
2. **Call Mother/Legal Guardian:**	_____	_____	_____
3. **Call Father/Legal Guardian:**	_____	_____	_____
4. _____ :	_____	_____	_____

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

❑ I understand that Benadryl will not be delegated on a field trip.

Parent/Guardian's Signature: _____ Date: _____

Revised 6/11