



GURNEE PARK DISTRICT – Allergy Action Plan

Participant's Name: _____ Program: _____

ALLERGY TO: _____

Asthmatic Yes* No *Higher risk of severe reaction

STEP 1: TREATMENT

Symptoms:

If a food allergen has been ingested, but no symptoms
Mouth: Itching, tingling, or swelling of lips, tongue, mouth
Skin: Hives, itchy rash, swelling of the face or extremities
Stomach: Nausea, abdominal cramps, vomiting, diarrhea
Throat: Tightening of throat, hoarseness, hacking/coughing
Lung: Shortness of breath, repetitive coughing, wheezing
Heart: Thready pulse, low blood pressure, fainting, pale, blueness
Other: _____
If reaction is progressing (several of the above areas affected) give

Give Checked Medication

<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Auvi-Q	<input type="checkbox"/> Do Nothing
<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine	<input type="checkbox"/> Auvi-Q	<input type="checkbox"/> Do Nothing
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Dosage:

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr Auvi-Q

Antihistamine: give _____
Medicine/dose/route

Other: give _____
Medicine/dose/route

STEP 2: EMERGENCY CALLS

- 1. Staff will call 911 if EpiPen Antihistamine Auvi-Q is given
- 2. Emergency Contacts if EpiPen Antihistamine Auvi-Q is given

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

If a parent or emergency cannot be reached when an ambulance arrives a staff member will accompany the child to the hospital.

Parent/Guardian Signature _____ Date: _____