OCMBOCES
Committed to Your Success

OCM BOCES/SUNYESF
Adirondack Field Studies Summer Program
Cranberry Lake

Date of trip: From _______________ to _______________

Allergy Action Plan

Student Name: ____ DOB: ___/___/______ ☐Male ☐Female

Allergic to: ____

Weight: ____________ lbs. Asthma: ☐Yes (higher risk for a severe reaction) ☐No

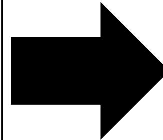
Extremely reactive to the following foods: ____
THEREFORE:
☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

Any SEVERE SYMPTON after suspected or known ingestion:

One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body

Or combinations of symptoms from different body areas;
SKIN: Hives, itchy rashes, swelling (e.g. eyes, lips)
GUT: Vomiting, diarrhea, crampy pain

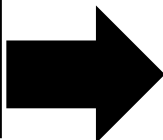


1. **INJECT PEINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (bee box below)
4. Give additional medications* as needed
   -Antihistamine
   - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTONS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort



1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals & parent
3. If symptoms progress (see above). USE EPINEPHRINE
4. Begin monitoring (see box below)

MEDICATIONS/DOSES
Epinephrine (brand & dose w/directions): ____
Antihistamine (brand & does): ____
Other (e.g. inhaler-bronchodilator if asthmatic): ____

Contacts: CALL 911 !

Physician Name: ______________________________________ Phone Number: (____) ____-______

Parent/Guardian Name: ________________________________ Phone Number: (____) ____-______

Other Emergency Contact(s):

Name/Relationship: ___________________________________ Phone Number: (____) ____-______

_____________________________ ___________ _________________________________ __________
Parent/Guardian Signature Date Physician/Healthcare Professional Signature Date