Allergy Action Plan

Parent/guardian, please complete the following:

Student name _____ Date of Birth _____

Teacher name _____ Grade _____

Parent/guardian name _____ Cell Phone _____

Allergies

Foods: _____

Medications: _____

Insects _____

Asthmatic? _____Yes, higher risk for severe reaction.

Symptoms/Treatment Plan

- Has come in contact with allergen, but no symptoms ___Ephinephrine ___Anthistamine
- Mouth: Itching, tingling, or swelling of lips, tongue ___Ephinephrine ___Anthistamine
- Skin: Hives, itchy rash, swelling of the face or extremities ___Ephinephrine ___Anthistamine
- Gut: Nausea, abdominal cramps, vomiting, diarrhea ___Ephinephrine ___Anthistamine
- Throat: Tightening of throat, hoarseness, hacking cough ___Ephinephrine ___Anthistamine
- Lung: Shortness of breath, repetitive coughing, wheezing ___Ephinephrine ___Anthistamine
- Heart: Thready pulse, low blood pressure, fainting, pale, blue ___Ephinephrine ___Anthistamine
- Other: _____ ___Ephinephrine ___Anthistamine
- If reaction progressing (several of the above areas affected), give ___Ephinephrine ___Anthistamine

Medicine / Dosage / Instructions

- Epinephrine: _____
- Antihistamine: _____
- Other: _____

____**Yes, if parent/guardian cannot be reached, do not hesitate to medicate or take child to medical facility!**

Parent/guardian signature _____ Date: _____

Emergency Contact Name _____ Phone: _____

Preferred Medical Facility: _____