

ALLERGY ACTION PLAN

ALLERGY TO: _____

Student's

Name: _____ DOB: _____ Teacher: _____

PLACE
CHILD'S
PICTURE
HERE

Asthmatic: Yes * No *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:

- **MOUTH**
- **THROAT***
- **SKIN**
- **GUT**
- **LUNG***
- **HEART***

Symptoms:

- itching and swelling of the lips, tongue, or mouth
- itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- hives, itchy rash, and/or swelling about the face or extremities
- nausea, abdominal cramps, vomiting, and/or diarrhea
- shortness of breath, repetitive coughing, and/or wheezing
- “thready” pulse, “passing out”

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION:

1. If ingestion is suspected, give _____
(medication/dose/route)
and _____ immediately!
2. CALL RESCUE SQUAD: _____
3. CALL: Mother _____ Father _____ or emergency contacts
4. Call: Dr. _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

Parent Signature Date

Doctor Signature Date

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. _____ Relation: _____ Phone: _____	1. _____ Rm. _____
2. _____ Relation: _____ Phone: _____	2. _____ Rm. _____
3. _____ Relation: _____ Phone: _____	3. _____ Rm. _____

INDIVIDUAL HEALTH CARE PLAN

NAME:

DATE:

DATE OF LAST REACTION:

DESCRIBE REACTION:

TREATMENT:

SPECIFIC CONSIDERATIONS: