Allergy Action Plan

Place Child's Picture Here

ALLERGY TO: _____

Student's Name: _____ D.O.B: _____ Teacher: _____

Asthmatic Yes ☐* No ☐ *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:	Symptoms:
•**MOUTH**	itching & swelling of the lips, tongue, or mouth
•**THROAT***	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
•**SKIN**	hives, itchy rash, and/or swelling about the face or extremities
•**GUT**	nausea, abdominal cramps, vomiting, and/or diarrhea
•**LUNG***	shortness of breath, repetitive coughing, and/or wheezing
•**HEART***	"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 / exposure is suspected, give _____ (medication/dose/route) and _____ immediately!
2. CALL RESCUE SQUAD: (Request epinephrine) _____
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!

_____ _____ _____ M.D. _____

Parent Signature Date Doctor's Signature Date

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

The Food Allergy Network

For children with multiple food allergies, use one form for each food. 5/95