Allergy Action Plan

Place Child's Picture Here

ALLERGY TO:_____

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

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

◆ SIGNS OF AN ALLERGIC REACTION ◆

Systems: **Symptoms: (Check most common reactions)**

☐	**•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 FOR MINOR REACTION ◆

1. If **only symptom(s)** are:_____, give_____
medication/dose/route

_____

2. Call Mother/Father at

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

◆ ACTION FOR MAJOR REACTION ◆

1. **If ingestion/sting is suspected and/or symptom(s) are:**_____

give_____IMMEDIATELY!
medication/dose/route

Then call:

2. Rescue Squad (ask for advanced life support)

3. Call Mother/Father at

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent's Signature_____**Date**_____ **Doctor's Signature**_____ **Date**____