

Allergy Action Plan



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 diarrh ea |
| • 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!

Parent Signature _____ Date _____ Doctor's Signature _____ M.D. _____ Date _____

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

