



Student's Name: _____ Grade _____ Allergic to: _____

Asthmatic: ____ yes* ____ no (* Higher risk for severe reaction)

This child last had an allergic reaction to _____ on (date) _____ that presented as:

SIGNS OF AN ALLERGIC REACTION

<u>System</u>	<u>Symptoms</u>
MOUTH	ITCHING AND SWELLING OF LIPS, TONGUE, MOUTH
THROAT	ITCHING AND OR TIGHTNESS IN THE THROAT, HOARSENESS AND COUGH
SKIN	HIVES, ITCHY RASH, AND/OR SWELLING OF THE FACE OR EXTREMITIES
GUT	NAUSEA, ABDOMINAL CRAMPS, VOMITING AND/OR DIARRHEA
LUNGS	SHORTNESS OF BREATH, REPETITIVE COUGHING AND/OR WHEEZING
HEART	"THREADY" PULSE, "PASSING OUT"

MINOR REACTION

If symptoms are:

1. Give _____
(Medication/Dose/Route of Administration – as directed on the attached Medication Request Form)
2. Then notify parent or other emergency contact.

MAJOR REACTION

If symptoms are:

1. Give _____ **IMMEDIATELY!**
(Medication (s)/ Dose/ Route of Administration – as directed on the attached Medication Request Form)
2. **Call 911.**
3. Notify parents, or emergency contacts and physician.

Physician's Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

Emergency Contact Information

Name _____ Relationship _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

Name _____ Relationship _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

Physician Name: _____

Phone: _____ Fax: _____

The completed Allergy Action Plan will be on file with the school nurse and a copy will be given to your child's teachers, as necessary.