2019-2020 ALLERGY ACTION PLAN

Medication is Kept (please check one): ☐ **Office** ☐ **Backpack** ☐ **Classroom**

STUDENT'S NAME: _____

ALLERGIC TO: _____

DOB: _____ TEACHER: _____

PARENT'S NAME: _____

ASTHMATIC (circle): YES NO

SIGNS OF ALLERGIC REACTION (circle all that apply):

Mouth:	Itching and swelling of 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 A MINOR REACTION

If symptom(s) are: _____,

give _____ (medication dose).

Then call: Mother at _____, or Father at _____

(over)

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

ACTION FOR MAJOR REACTION

If symptoms are _____

Give _____ (medication dose) **IMMEDIATELY**

CALL 9-1-1

Then call Mother at _____ and Father at _____

EMERGENCY CONTACTS:

Name	Relationship	Phone Number

Parent Signature and date: _____