School Year: _____ - _____

Developing Christlike Character
and Academic Excellence

Allergy Action Plan

Student Name: ____

Age: ________ Birthdate: ______________________ Date diagnosed: ________________________________

Health Care Provider: ___________________________ Clinic: ______________________________________

Phone (of physician): ___________________ Hospital choice: _______________________________________

Allergy to: ____

Please indicate the student's usual symptoms when exposed to allergen:

Mouth	☐ Itching	☐ Swelling of the lips, tongue	☐ Swelling of the mouth	
Throat	☐ Itching	☐ Sense of tightness in throat	☐ Hoarseness	☐ Hacking cough
Skin	☐ Hives	☐ Itchy rash	☐ Swelling about the face or extremities	
Gut	☐ Nausea	☐ Abdominal cramps	☐ Vomiting	☐ Diarrhea
Lungs	☐ Shortness of breath	☐ Repetitive coughing	☐ Wheezing	
Heart	☐ “thready” pulse	☐ Passing out		

Action for MINOR Reaction:

If only symptoms are: ____, give ____________________________

____

Then call:

☐ mother (_____)______-___________ ☐ father (_____)______-____________ ☐ emergency contacts

☐ physician: _____________________________ (_____)______-____________

Action for MAJOR Reaction:

If ingestion is suspected and/or symptoms are: ____

administer ____ IMMEDIATELY!

Then call:

☐ Rescue Squad (ask for advanced life support)

☐ mother (______)______-___________ ☐ father (_____)______-____________ ☐ emergency contacts

☐ physician: _____________________________ (_____)______-____________

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent Signature: ____________________ Date: ______ Physician Signature: ______________________ Date: _____

This form was completed by: __________________________ relationship to student: ________________ Date: _______

____ ________________________

Parent/Guardian signature Date