

Allergy Action Plan

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
- THROAT
- SKIN
- GUT
- LUNG
- HEART

itching & swelling of the lips, tongue, or mouth
 itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
 hives, itchy rash, and/or swelling about the face or extremities
 nausea, abdominal cramps, vomiting, and /or diarrhea
 shortness of breath, repetitive coughing, and/or wheezing
 "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 : _____

If condition does not improve with 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. 911 (ask for advance life support)

3. Call Mother/Father at _____

DO NOT HESITATE TO CALL 911!

Parent's Signature _____ Date _____ Doctor's Signature _____ Date _____