



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	<input type="checkbox"/> Itching	<input type="checkbox"/> Swelling of the lips, tongue	<input type="checkbox"/> Swelling of the mouth	
Throat	<input type="checkbox"/> Itching	<input type="checkbox"/> Sense of tightness in throat	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Hacking cough
Skin	<input type="checkbox"/> Hives	<input type="checkbox"/> Itchy rash	<input type="checkbox"/> Swelling about the face or extremities	
Gut	<input type="checkbox"/> Nausea	<input type="checkbox"/> Abdominal cramps	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea
Lungs	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Repetitive coughing	<input type="checkbox"/> Wheezing	
Heart	<input type="checkbox"/> "thready" pulse	<input type="checkbox"/> 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 _____