ALLERGY ACTION PLAN

Homeroom Teacher:_____ Allergy to:_____

Student Name:_____ Grade: _____

Address:_____ Home Phone:_____

Mother/Guardian:_____ Cell/Work Phone:_____

Father/Guardian:_____ Cell/Work Phone:_____

Physician:_____ Phone:_____

In case of an emergency when parents cannot be reached, contact:

Name:_____ Phone:_____

Does your child also have asthma: _____ Yes _____ No

What are the symptoms your child shows in a food allergy reaction? (check all that apply)

_____ MOUTH- itching and swelling of the 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- "thread" pulse, "passing out"

_____OTHER-_____

Steps you wish the school staff to follow if your child has a **MINOR REACTION:**

1. _____
2. _____
3. _____

Steps you wish the school staff to follow if your child has a **MAJOR REACTION:**

1. Call 911
2. _____
3. _____