Allergy Action Plan
PARENT OR GUARDIAN TO COMPLETE

Student Name: _____ D.O.B._____ Program: ERfC

ALLERGY TO: _____

Asthmatic Yes* ☐ No ☐ * Higher risk for severe reaction

Has your child had a previous allergic reaction? Yes ☐ No ☐

Was your child brought to the Emergency Room? Yes ☐ No ☐

Symptoms

PLEASE CIRCLE SYMPTOMS CHILD HAS EXPERIENCED IN THE PAST:

- Mouth — Itching, tingling, or swelling of lips, tongue, mouth
- Skin — Hives, itchy rash, swelling of the face or extremities
- Gut — Nausea, abdominal cramps, vomiting, diarrhea
- Throat ☹ — Tightening of throat, hoarseness, hacking cough
- Lung ☹ — Shortness of breath, repetitive, coughing, wheezing
- Heart ☹ — Thready pulse, low blood pressure, fainting, pale, blueness
- Other ☹ — _____

The severity of symptoms can quickly change. ☹ Potentially life-threatening.

STEP ONE – TREATMENT:

Epinephrine: Inject intramuscularly (circle one) EpiPen EpiPen Jr. Other: _____

Antihistamine: give _____

Other: give _____

STEP TWO: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Parent/Guardian:

Name/Relationship	Phone #1	Phone #2
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____

3. Call ERfC office to report incident

Parent/Guardian Signature _____ Date _____

Health Care Consultant Signature _____ Date _____

Signature of the staff responsible for _____(name of child)

Printed Name	Signature	Date Signed	Printed Name	Signature	Date Signed