



Allergy Action Plan

Student Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Male Female Grade _____ Phone _____

Allergy Information Student is Allergic to: _____

Student's reaction includes the following: (x the ones that apply)

- Confusion
- Difficulty Breathing
- Dizziness
- Drooling Or Difficulty Swallowing
- Flushed Face
- Itchy, Sneezing, Runny Nose
- Loss Of Consciousness
- Hives All Over Body
- Paleness
- Rash
- Red, Watery Eyes
- Seizures
- Several Hives On One Part Of Body
- Weakness
- Other: _____

How often is your child medicated for allergy? _____

Should medication be available at school? Yes No

(If the answer is yes, a "Dispensing Medication at School" form must be on file and medication must be provided by the parents in its original container)

Please list the steps you would like school personnel to follow, in the event of an allergic reaction or emergency situation. (Include phone numbers—any medication that needs to be given must be provided by the family.)

1. _____
2. _____
3. _____
4. _____

Signature of Parent _____

Mother's Name _____ Day Phone _____ Cell _____

Father's Name _____ Day Phone _____ Cell _____

Please list two available alternates to attempt to contact in an emergency:

1. (name/relationship to student) _____ Day Phone _____
2. (name/relationship to student) _____ Day Phone _____

Physician Name _____ Clinic Name _____

Phone: Clinic _____ Physician's Emergency Phone _____

Dentist Name _____ Clinic Name _____

Phone: Clinic _____ Dentist's Emergency Phone _____