

Allergy Action Plan

Student Name: _____ Birth Date: _____
 School: _____ Grade: _____ Teacher: _____

ALLERGIC TO THESE ALLERGENS: _____

- Has Asthma** (increases risk for severe reaction)
- Severe Allergy previously/suspected** Immediately give epinephrine & call 911 Start with Steps 2 & 3
- Mild Allergy** Itching, rash, hives **Give antihistamine, call school nurse and parent. Start with Step 1**

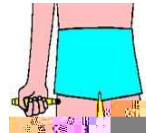
STEP 1: IDENTIFICATION OF SYMPTOMS

* Send for immediate adult assistance

Symptoms:

Type of Medication to Give:

(Determined by physician authorizing treatment)



This form must be renewed annually or with any change in medication.
 The Medication Administration Form must be completed in addition to this Allergy Action Plan