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**

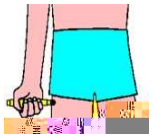
☐ **Mild Allergy** Itching, rash, hives **Give antihistamine, call school nurse and parent. Start with Step 1**

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*