2024-2025 Health Action Plan for Allergy

Attach your child's photo here.

ALLERGY TO:_____

Student's Name_____ Grade_____ (A) (B)

Date of Birth:_____ Teacher_____

Physician:_____ Phone:_____

Asthmatic (please circle): Yes No *High risk for sever reaction.

Circle any/all of the following symptoms your child has experience with their allergy:

System	Symptoms
Mouth	Itching and swelling of 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	"Thready" pulse, "passing-out"

Other:_____

In the past, how has their allergy been treated?_____

(Benadryl, epi-pen, hospitalized intubation, etc.)

Note: The severity of symptoms can quickly change and progress to a life threatening condition. Therefore, in order to expedite emergency care for you child, please specify which symptoms your health care provider wants us to treat.

If your child has these symptoms:_____

Give_____ (provide medication, dose, and route).

Then call_____ at_____ (specify parent, 911).

Other important information pertinent to your child's allergy:

_____

_____

_____

Parent Signature:_____ Date:_____

Physician's Signature_____ Date:_____

Please note if an epi-pen is needed for treatment. Please provide two epi-pens so they may be placed in readily accessible locations appropriate to child's needs.

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Date received by the Health room:_____ Signed_____