# Allergy Action Plan

Place Child's Picture Here

**ALLERGY TO:** ____________________

Student's Name: ____________________ D.O.B: ____________ Teacher: ____________

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

## ◆ SIGNS OF AN ALLERGIC REACTION ◆

| Systems: | Symptoms: |
|---|---|
| •MOUTH | itching & swelling of the 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" |

**The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.**

## ◆ ACTION FOR MINOR REACTION ◆

1. **If only symptom(s) are:** ____________________, give ____________________ (medication/dose/route)

____________________

Then call:

2. Mother ____________________, Father ____________________, or emergency contacts.
3. Dr. ____________________ at ____________________

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

## ◆ ACTION FOR MAJOR REACTION ◆

1. **If ingestion is suspected and/or symptom(s) are:** ____________________,

give ____________________ (medication/dose/route) IMMEDIATELY!

Then call:

2. Rescue Squad (ask for advanced life support)
3. Mother ____________________, Father ____________________, or emergency contacts.
4. Dr. ____________________ at ____________________

**DO NOT HESITATE TO CALL RESCUE SQUAD!**

Parent's Signature ____________________ Date ______ Doctor's Signature ____________________ Date ______

## AUTHORIZATION FOR MEDICATION OR TREATMENT

To the Parent or Adult Student:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO POSSESS OR USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

| ______________________________ | ______________ |
|---|---|
| Name of Student | Telephone |
| Address | Date of Birth |
| School | Room |

1. I am requesting permission for my child named above to: (Check one or both)

   ______ use or receive medication

   ______ receive treatment

   in accordance with the Doctor's prescription.

2. I will assume responsibility for safe delivery of the medication to school, either by me or by my child.

3. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

4. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

______________________________ ______________

Signature of Parent or Adult Student — Date

______________________________ ______________

Home Telephone — Work Telephone

## PHYSICIAN STATEMENT

To the Physician:

The Board of Education urges you to schedule, to the extent possible, medication or treatment of a student outside of school hours. When that is not possible, medications and/or treatment will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I have prescribed the following to be administered to ____________________
Student

____________________ ____________________
Medication Dosage

Medication is to be taken at the following times ____________________

Instructions or precautions (including possible side effects): ____________________

____________________

____________________

____________________
Treatment

Beginning Date ____________________ Expiration Date ____________________

Physician ____________________ Telephone ____________________

Printed/Typed Name ____________________ Date ____________________

## AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s) to the student:

____________________

____________________

____________________

____________________
Principal