

Allergy Action Plan

(General Form)

ALLERGY TO: _____

Student's Name _____ DOB _____ Teacher _____

Has Asthma 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 &/or a sense of tightness in the throat, hoarseness, & hacking cough
Skin	Hives, itchy rash, &/or swelling about the face or extremities
Gut	Nausea, abdominal cramps, vomiting, &/or diarrhea
Lung	Shortness of breath, repetitive coughing, &/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

If only symptom(s) are: _____, give _____

Then call:

1. Mother _____ Father _____ or emergency contacts.

2. Dr. _____ at _____

If condition does not improve within 10 minutes, follow steps 1-3 below.

ACTION FOR MAJOR REACTION

If symptoms(s) are: _____

give _____ **IMMEDIATELY!**

Then call:

1. Rescue Squad (ask for advanced life support)

2. Mother _____ Father _____ or emergency contacts.

3. Dr. _____ at _____