ALLERGY ACTION PLAN

Allergy to: ____________________________________________________________

Student Name: ___________________________________________ School/Grade: ____________________________

Physician: ___________________________ Preferred Hospital: ____________________________

In case of an emergency when parents cannot be reached, contact:

Name: ___________________________________________ Phone: ____________________________

Does your child also have asthma?: _____ Yes _____ No

Does your child require an Epinephrine Auto Injector?: _____ Yes _____ No

If YES, please take an Illinois Food Allergy Emergency Action Plan to complete with your child’s healthcare provider.

Where do you prefer the Epinephrine be stored?: _____ Classroom _____ School Office _____ Carried/Backpack

What are the symptoms your child shows during an allergic reaction? (Check all that apply)

_____ MOUTH- itching and 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”

_____ OTHER- ____________________________

Steps you wish the school staff to follow if your child has a MINOR REACTION: (Medications must have proper consent.)

_____ ______

Steps you wish the school staff to follow if your child has a MAJOR REACTION: (Medications must have proper consent.)

1. Call 911

2. ____________________________

I hereby authorize District Health Staff to contact the medical provider named here __________________ regarding this medical condition and to release information regarding my child (named above) to said provider. I hereby authorize the medical provider to release information about my child and this medical condition/allergy to District Health Staff regarding any medical concerns or medications needed regarding this Allergy Plan.

I also give permission for the School Administration/School Nurse to contact the medical provider about information contained in this Allergy Action Plan.

Date_________________________ Parent/Guardian Signature ____________________________

Printed Name_________________________ Phone Number: ____________________________