

Allergy Action Plan

This form is required for all students with severe allergies that require an Epi-Pen to be kept at Trinity Lutheran School. Parent and Physician Signatures are required.

Child's name _____ Birth date _____

Teacher's name _____ Grade _____

Allergic to _____

Custodial Parent's name(s) _____

Primary phone number _____ Home Cell Work _____

Secondary phone number _____ Home Cell Work _____

Child's Physician _____ Phone _____

Describe how your child reacts to exposure to particular allergens:

ACTION PLAN FOR MILD ALLERGIC REACTION

If child exhibits mild symptoms such as _____

administer _____ (amount) of _____ (medicine).

Call parent? YES / NO Call physician? YES / NO

NOTES: _____

If after 10 minutes, the condition does not improve or worsens, follow the action plan for severe allergic reaction below

ACTION PLAN FOR SEVERE ALLERGIC REACTION

If child exhibits mild symptoms such as _____

administer _____ (amount) of _____ (medicine) immediately.

1. Epi Pen? YES / NO 2. Call 911 immediately. 3. Call parents next 4. Call physician

NOTES: _____

Parent's signature _____ Date _____

Physician's signature _____ Date _____