CLEARVIEW PREP
PRESCHOOL

ALLERGY ACTION PLAN

ALLERGY TO: _____

Student's Name _____
Please attach child's picture to the top right corner of this form.

Asthmatic: Yes* □ No □ *High risk for severe reaction **Weight**: ____ lbs. **D.O.B**.: __/__/__

∴ SIGNS OF AN ALLERGIC REACTION

Systems	Symptoms*
MOUTH	Itching and swelling of the lips, tongue or mouth
THROAT	Itching and/or a sense of tightness in the throat, hoarseness or hacking cough
SKIN	Hives, itchy rash and/or swelling about the face or extremities
GASTROINTESTINAL	Nausea, abdominal cramps, vomiting and/or diarrhea
LUNG	Shortness of breath, repetitive coughing and/or wheezing
HEART	"Thready" pulse, unconsciousness or "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: _____

_____

Then call:

1. Mother _____, 2. Father _____, or emergency contact person.

3. Doctor _____ at _____.

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

∴ ACTION FOR MAJOR REACTION

If ingestion is suspected and/or symptoms(s) are: _____,

give _____ IMMEDIATELY!
(medication/dose/route)

Then call:
1. Rescue Squad (ask for advanced life support)
2. Mother _____, Father _____, or emergency contact person.
3. Doctor _____ at _____.

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent's Signature _____ **Date** _____

Doctor's Signature _____ **Date** _____