MOUNT VIEW PRIMARY SCHOOL

Allergy Action Plan

Photo of child

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 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 _____

ACTION FOR MAJOR REACTION

1. **If symptom(s) are:** _____ give(medication/dose/route) _____
   _____ IMMEDIATELY!

Then call:

2. **AMBULANCE (OOO) MICA (LIFE SUPPORT)**
3. **Mother_____, Father_____, or emergency contacts._____**
   _____
4. **Dr. _____ at _____**

Allergist Name _____ **Provider no** _____ **Phone** _____
Parent's Signature _____ **Date** _____ **Doctor's Signature** _____ **Date** _____