

ALLERGY ACTION PLAN

Student Name: _____

Teacher or Homeroom: _____ Grade: _____

Allergy: _____

1) Rate the severity of your child's allergic reaction. (Circle One)
(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

2) Check any life-threatening allergy your child has:

_____ Insect sting (list type) _____

_____ Food (list type) _____

_____ Animal (list type) _____

_____ Other (list) _____

3) What symptoms does your child exhibit when they are exposed to the allergen?
(Check all that apply)

_____ rash _____ nausea and/or vomiting

_____ watering eyes _____ coughing

_____ difficulty breathing _____ hives

_____ difficulty swallowing _____ loss of consciousness

_____ swelling on any part of _____ flushed or unusually pale skin

body (where and how much) _____ other (list)

4) What does your child do at home to relieve their symptoms during an allergic reaction?

_____ rest/relaxation _____ washes hands/face _____ takes medicine

(please list any medications) _____

_____ other (please list) _____

5) Please list if you child takes any daily medication. (name, strength and how often)

6) Has emergency medical treatment been needed in past year for allergies?

_____ No _____ Yes (when) _____

7) Allergies are currently being treated by Dr. _____ Phone: _____

8) If your child suffers an allergic reaction at school, what plan of action would you prefer the school personnel to take?

PLEASE TURN OVER

Thank you for your time and assistance in assessing your child's special needs at school. Please initial the following:

1. I authorize permission for this information to be shared with any school personnel (including substitute teachers) who would be responsible for my child during the school day. _____
2. I give permission that a letter may written by the principal to be sent home regarding that there is a child in the classroom with allergies and what type of allergies. This letter will include a request that all students and parents voluntarily refrain from sending/bringing foods that can cause an allergic reaction to school. _____
3. I understand and permit that my child may have preferential seating especially in the cafeteria and on the bus. I will teach my child to recognize the first symptoms of an allergic reaction and to notify an adult immediately if such symptoms occur or if he/she has been exposed to an allergen so he/she may be monitored. If my child has rescue medication that the doctor prescribes to keep with him/her at all times, I will verify each morning that it is present in backpack. _____
4. I will provide the emergency contact information and completed required forms/documentation from my child's doctor that is provided with this action plan. I will inform the school nurse immediately of changes in orders, condition, or emergency contact information. _____
5. I give permission to a trained teacher or volunteer health aide to recognize an anaphylaxis emergency and carry out the care tasks outlined in the Allergy Action Plan. I understand that no school employee, including a teacher, volunteer health aide, school nurse, school bus driver, cafeteria staff, or any other officer or agent of a board of education, shall be held liable for any good faith act or omission. _____
6. I give permission to emergency transport for my child by ambulance when necessary and do not hold the school corporation responsible for any charges that are incurred. _____

EMERGENCY CONTACT:

<u>Name</u>	<u>First Number</u>	<u>Second Number</u>	<u>Third Number</u>

Parent signature: _____ Date: _____