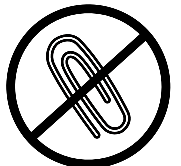
PLEASE DO NOT WRITE ABOVE THIS LINE - FOR MAGNUS HEALTH USE ONLY

ALLERGY ACTION PLAN FORM

This coversheet is **ONLY** for the form and student listed above and **MUST BE RECEIVED** for processing.

DO NOT use staples or paperclips!



Please print and complete this form then submit all pages including this coversheet via:

FAX		MAIL
(877) 447-9530 Outside of the United States? Please fax to (978) 244-8894	-OR-	**Magnus Health Does Not Accept Mailed Forms**

EMERGENCY HEALTH CARE PLANS

(to be filled in by Physician)

Student: ______________________________ Date: ______________________

FOR MANAGEMENT OF SEVERE ALLERGIC REACTIONS

Severe Allergy to: ______________________________

Stage I:

With early signs including skin, GI, respiratory, or cardiac symptoms, including "thready" pulse, or loss of consciousness.

IF REACTION IS SUSPECTED, GIVE ______________________ by mouth immediately.

Call parents, guardian, or emergency contacts immediately.

Stage II:

If symptoms develop in 2 or more systems or if throat, lung, or heart symptoms develop:

Give EPINEPHRIN INJECTION immediately!

Call RESCUE SQUAD immediately.

Call PARENTS/GUARDIAN immediately.

STUDENT ASTHMA PLAN

Identify likely causes of asthma onset: ______________________________

Peak Flow Monitoring: ______________________ Personal Best Flow: ______________________

Daily Medication Plan: ______________________________

____

STUDENT DIABETES PLAN

Insulin/Glucagon/Other Rx: ______________________________

____

Signature of Physician: ______________________________

Phone Number: ______________________

[affix stamp here]