WAYNE COUNTY SCHOOL DISTRICT

Allergy Action Plan

Student's Name_____ Date of Birth_____
School_____ Teacher/Grade:_____
Parent/Guardian:_____
Home Phone_____Work Phone_____ Cell Phone_____

Allergic to: ☐ Bee Sting ☐ Food (specify)_____
☐ Other(specify)_____

********** **Medical documentation of food allergies is required to be submitted yearly**********

SIGNS OF ALLERGIC REACTION (check all that apply to your child)

☐ Itching ☐ Rash ☐ Swelling or redness at sting site
☐ Hives ☐ Nausea/Vomiting ☐ Itching/swelling lips, tongue, or mouth
☐ Other (specify)_____ ☐ Trouble breathing, swallowing, talking

I would rate the severity of my child's allergy as (please circle one)

Not Severe 1 2 3 4 5 Severe

- WCSD Policy states that designated personnel may carry emergency meds on field trips.
- If your child must carry emergency meds at all times, please have the "Release-To-Carry Form" for Asthma Inhaler, Anaphylaxis Medication and/or Insulin Supplies filled out and on file.

TREATMENT (To Be Filled Out By Physician)

1. Administer_____Dose_____Route_____
   if symptoms are_____
2. Administer_____Dose_____Route_____
   if symptoms are_____
3. ***Call 911 if epinephrine auto-injector is given or if reaction is severe or if emergency meds are not available.***
4. Call parents or emergency contacts.

_____ _____
Physician Signature **Date**

_____ _____
Parent Signature **Date**

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