Allergic Reaction Action Plan For School

(To Be Completed By Health Care Provider and Parent)

Student Name: _____ **Date of Birth:** _____

Trigger(s): _____

Daily Medication(s): _____

1. Safe Zone:	**1. Action:**
Child has no symptoms of allergic reaction and had no exposure to any trigger.	❑ Avoid trigger(s).

2. Caution Zone:	**2. Action:**
Child has been exposed to trigger.	❑ Closely observe child for 2 hours for signs of allergic reaction. ❑ Give _____medication(s). (If EpiPen, must call 911 after given.) ❑ Notify parent.

3. Danger Zone:	**3. Action:**
Child has any of the following: ❑ Rash or hives ❑ Unusual swelling ❑ Gastric upset/distress ❑ Complaints of itching ❑ Other:_____	❑ Use _____medication(s). (If EpiPen, must call 911 after given.) ❑ Notify parent. ❑ Notify doctor.

4. Extreme Danger Zone:	**4. Action:**
Child has any of the following: ❑ Difficulty breathing, wheezing, repetitive cough ❑ Faint, rapid pulse ❑ Loss of consciousness ❑ Other:_____	❑ Use _____medication(s). (If EpiPen, must call 911 after given.) ❑ Call 911. ❑ Give CPR if needed until EMS arrives.

HealthCare Provider: _____ Phone#_____

(Please Print) Fax#_____

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date:_____

Home Phone#_____ Work Phone#_____ Cell Phone#_____

It is the responsibility of the parent and physician to notify the school and provide an updated plan upon any changes.