

Allergy Action Plan

Students Name: _____

Allergy to: _____ D.O.B.: _____ School: _____



Asthmatic Yes* No *High risk for severe reaction

◆ SIGNS OF AN ALLERGIC REACTION ◆

Systems:

Symptoms:

MOUTH

Itching and swelling of the lips, tongue or mouth

THROAT *

Itching and/or a sense of tightness in the throat, hoarseness and hacking coughing

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 _____,

Then call:

2. Parent/Guardian: _____, or _____,

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

◆ ACTION FOR MAJOR REACTION ◆

1. If ingestion is suspected and/or symptom(s) are: _____, give _____ IMMEDIATELY!

Then call:

2. Rescue Squad (ask advice life support)

3. Parent/Guardian: _____ or _____, or emergency contacts.

Parent/Guardian Signature: _____

Date: _____

Doctor Signature: _____

Date: _____

YWCA Staff Signature: _____

Date: _____

YWCA Staff Signature: _____

Date: _____

YWCA Staff Signature: _____

Date: _____