



ALLERGY ACTION PLAN

Child's Name: _____ D.O.B. _____

Allergy to: _____

Asthmatic: ____ No ____ Yes, high risk for severe reaction

*****Signs of an allergic reaction*****

<u>Systems:</u>	<u>Symptoms:</u>
Mouth	itching and swelling of the lips, tongue or mouth
Throat**	itching and/or a sense of tightness in the throat, hoarseness, hacking cough
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

**symptoms can potentially progress to a life threatening situation

ACTION FOR MINOR REACTION

1. If the only symptom(s) are: _____,
give _____
(medication/dose/route)

Then call:

2. Parents or emergency contact.
3. Dr. _____ at (phone) _____.

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

ACTION FOR MAJOR REACTION

1. If the symptom(s) are: _____,
give _____ IMMEDIATELY!!!!
(medication/dose/route)

Then call:

2. **911** and ask for advanced life support – DO NOT HESITATE TO CALL
3. Parents or emergency contact.
4. Dr. _____ at (phone) _____.

Parent's Signature _____ Date _____

Doctor's Signature _____ Date _____