Constellation Schools

Old Brooklyn Community Elementary
Old Brooklyn Community Middle

"The Right Choice for Parents and a Real Chance for Children"

Allergy Action Plan

Student's Name: _____ Grade _____ Allergic to: _____

Asthmatic: _____ yes* _____ no (* Higher risk for severe reaction)

This child last had an allergic reaction to_____ on (date) _____ that presented as:

_____

_____

SIGNS OF AN ALLERGIC REACTION

System	Symptoms
MOUTH	ITCHING AND SWELLING OF LIPS, TONGUE, MOUTH
THROAT	ITCHING AND OR TIGHTNESS IN THE THROAT, HOARSENESS AND COUGH
SKIN	HIVES, ITCHY RASH, AND/OR SWELLING OF THE FACE OR EXTREMITIES
GUT	NAUSEA, ABDOMINAL CRAMPS, VOMITING AND/OR DIARRHEA
LUNGS	SHORTNESS OF BREATH, REPETITIVE COUGHING AND/OR WHEEZING
HEART	"THREADY" PULSE, "PASSING OUT"

MINOR REACTION

If symptoms are:

_____

1. Give _____
   (Medication/Dose/Route of Administration – as directed on the attached Medication Request Form)
2. Then notify parent or other emergency contact.

MAJOR REACTION

If symptoms are:

_____

1. Give _____IMMEDIATELY!
   (Medication (s)/ Dose/ Route of Administration – as directed on the attached Medication Request Form)
2. **Call 911.**
3. Notify parents, or emergency contacts and physician.

Physician's Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Emergency Contact Information

Name _____ Relationship _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

Name _____ Relationship _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

Physician Name: _____

Phone: _____ Fax: _____

The completed Allergy Action Plan will be on file with the school nurse and a copy will be given to your child's teachers, as necessary.