



Constellation Schools
Stockyard Community Elementary and 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

MOUTH
 THROAT
 SKIN
 GUT
 LUNGS
 HEART

Symptoms

ITCHING AND SWELLING OF LIPS, TONGUE, MOUTH
 ITCHING AND OR TIGHTNESS IN THE THROAT, HOARSENESS AND COUGH
 HIVES, ITCHY RASH, AND/OR SWELLING OF THE FACE OR EXTREMITIES
 NAUSEA, ABDOMINAL CRAMPS, VOMITING AND/OR DIARRHEA
 SHORTNESS OF BREATH, REPETITIVE COUGHING AND/OR WHEEZING
 "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.