Allergy Care Plan

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____

ALLERGY TO: _____

Is the child high risk for a severe reaction? Yes _____No

GENERAL SIGNS OF SEVERE ALLERGIC REACTION

Mouth – itching and swelling of lips, tongue, or mouth
Throat* - itching and/or a sense of tightness in throat, hoarseness, and hacking cough
Skin – hives, itchy rash, and/or swelling of face or extremities
Gut – nausea, abdominal cramps, vomiting and/or diarrhea
Lung* - shortness of breath, repetitive coughing and/or wheezing
Heart* - "thread pulse", "passing out"

Note: The severity of symptoms can change quickly.
*These symptoms can potentially progress to a life-threatening situation.

IF EXPOSURE TO ALLERGEN IS SUSPECTED AND/OR SYMPTOMS ARE:

_____
_____
_____

THEN THE FOLLOWING STEPS SHOULD BE TAKEN (i.e. medication, call 911):

_____
_____
_____

Parent Name: _____ Phone: _____
Parent Name: _____ Phone: _____

Additional Information (if needed): _____
_____
_____

Physician's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____