ALLERGY ACTION PLAN

Student Name: _____
Teacher or Homeroom: _____ Grade: _____
Allergy: _____

1) Rate the severity of your child's allergic reaction. (Circle One)
(not severe) 1 2 3 4 5 6 7 8 9 10 (severe)

2) Check any life-threatening allergy your child has:
_____Insect sting (list type)_____
_____Food (list type)_____
_____Animal (list type)_____
_____Other (list)_____

3) What symptoms does your child exhibit when they are exposed to the allergen? (Check all that apply)

_____rash	_____nausea and/or vomiting
_____watering eyes	_____coughing
_____difficulty breathing	_____hives
_____difficulty swallowing	_____loss of consciousness
_____swelling on any part of body (where and how much)	_____flushed or unusually pale skin
	_____other (list)

4) What does your child do at home to relieve their symptoms during an allergic reaction?
_____rest/relaxation _____washes hands/face _____takes medicine
(please list any medications)_____
_____other (please list)_____

5) Please list if you child takes any daily medication. (name, strength and how often)
_____

6) Has emergency medical treatment been needed in past year for allergies?
____No _____Yes (when)_____

7) Allergies are currently being treated by Dr._____ Phone:_____

8) If your child suffers an allergic reaction at school, what plan of action would you prefer the school personnel to take?
_____
_____
_____
_____

PLEASE TURN OVER

Thank you for your time and assistance in assessing your child's special needs at school. Please initial the following:

1. I authorize permission for this information to be shared with any school personnel (including substitute teachers) who would be responsible for my child during the school day._____

2. I give permission that a letter may written by the principal to be sent home regarding that there is a child in the classroom with allergies and what type of allergies. This letter will include a request that all students and parents voluntarily refrain from sending/bringing foods that can cause an allergic reaction to school. _____

3. I understand and permit that my child may have preferential seating especially in the cafeteria and on the bus. I will teach my child to recognize the first symptoms of an allergic reaction and to notify an adult immediately if such symptoms occur or if he/she has been exposed to an allergen so he/she may be monitored. If my child has rescue medication that the doctor prescribes to keep with him/her at all times, I will verify each morning that it is present in backpack. _____

4. I will provide the emergency contact information and completed required forms/documentation from my child's doctor that is provided with this action plan. I will inform the school nurse immediately of changes in orders, condition, or emergency contact information._____

5. I give permission to a trained teacher or volunteer health aide to recognize an anaphylaxis emergency and carry out the care tasks outlined in the Allergy Action Plan. I understand that no school employee, including a teacher, volunteer health aide, school nurse, school bus driver, cafeteria staff, or any other officer or agent of a board of education, shall be held liable for any good faith act or omission. _____

6. I give permission to emergency transport for my child by ambulance when necessary and do not hold the school corporation responsible for any charges that are incurred._____

EMERGENCY CONTACT:

Name	**First Number**	**Second Number**	**Third Number**

Parent signature:_____Date:_____