ALLERGY ACTION PLAN

Student Name:_____

Grade/Teacher: _____ **EPI PEN? Yes or No (please circle one)**

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

   _____rash _____swelling around the eyes

   _____watering eyes _____coughing

   _____hives _____wheezing

   _____difficulty breathing _____tongue swelling

   _____ other (please list):_____

3. What does your child do at home to relieve their symptoms during an allergic reaction?

   _____rest/relaxation _____washes hands/face

   _____takes medication (please list):_____

   _____

4. Please list if your child takes any daily medication
   Name of medication(s):_____

   _____

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

   _____

Thank you for your time and assistance in assessing your child's special needs at school. By signing this form, you authorize permission for this information to be shared with any school personnel who will be responsible for your child during the school day. Thanks!

Parent Signature:_____ Date: _____