



ALLERGY ACTION PLAN

ALLERGIC TO					<i>INSERT STUDENT'S PICTURE HERE - MAXIMUM WIDTH 2.5"</i>
STUDENT NAME					
ADDRESS					
DATE OF BIRTH		AGE			
DATE PREPARED		WEIGHT			
TEACHER		GRADE			
ASTHMATIC	<input type="checkbox"/>	*YES	<input type="checkbox"/>	NO	
	*YES → HIGH RISK FOR MAJOR REACTION				

✦ SIGNS OF AN ALLERGIC REACTION ✦

SYSTEMS

- *MOUTH
- *THROAT*
- *SKIN
- *GASTROINTESTINAL
- *LUNG*
- *HEART*

SYMPTOMS

- itching & swelling of the lips, tongue or mouth
- itching or a sense of tightness in the throat, hoarseness and hacking cough
- hives, itchy rash, and/or swelling about the face or extremities
- nausea, abdominal cramps, vomiting, and/or diarrhea
- shortness of breath, repetitive coughing, and/or wheezing
- “thready” pulse, “passing out”

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

✦ ACTION FOR MILD REACTION ✦

1. If only symptom(s) are:

(symptoms)

Give:

(medication/dose/route)

ALLERGIC TO				
STUDENT NAME				



2. Then call Mother, Father, Guardian, or emergency contacts in the following order:

	Name	Relationship	Phone Number(s)
1			
2			

3. Add any additional steps (for example, call the student's doctor). Leave blank if no additional steps.

1	
2	

4. If condition does not improve within minutes, follow steps for Severe Reaction below.

ACTION FOR SEVERE REACTION



1. If symptom(s) are:

(symptoms)

Give:

(medication/dose/route)

2. Call 911. (Note: This form may be given to emergency/hospital personnel.) Explain nature of problem and ask for advanced life support including epinephrine.

3. Then call Mother, Father, Guardian, or emergency contacts in the following order:

	Name	Relationship	Phone Number(s)
1			
2			

4. Add any additional steps (for example, call the student's doctor). Leave blank if no additional steps.

1	
2	

DO NOT HESITATE TO CALL 911!

ALLERGIC TO	<input type="text"/>
STUDENT NAME	<input type="text"/>



ADDITIONAL QUESTIONS	YES	NO	PARENT/GUARDIAN COMMENTS
Should your child carry an EpiPen®, EpiPen Jr.®, Twinject®, and/or Benedryl® at all times? If no, we will take reasonable efforts to store the child's medicine in the school so it can be accessed easily.			
Will your child carry an EpiPen®, EpiPen Jr.®, Twinject®, and/or Benedryl® in his/her backpack?			
Can your child self-administer an EpiPen®, EpiPen Jr.®, Twinject®, and/or Benedryl®?			
For Parents/Guardians of a student at risk for anaphylactic shock and who use an EpiPen®, EpiPen Jr.®, or Twinject®, do you want to accompany your child on school field trips?			
Are you comfortable with your child obtaining drinks from a water fountain? ** If no, the child may bring a water bottle from home.			

** Note that we are a Nut Restricted School, which signifies that all reasonable precautions will be taken so that peanuts and tree nuts are not be eaten in the school during school hours in areas being used by the school children, except in approved Nut Zone area(s).

PLEASE INCLUDE ANY ADDITIONAL INSTRUCTIONS/COMMENTS ON ANOTHER SHEET AND ATTACH IT TO THIS DOCUMENT.

I understand:

- these guidelines will remain in effect for the current school year and will notify the school administrator and/or school nurse if revisions must be made.
- it is my responsibility to alert the bus driver of my child's condition and provide specific instructions for them.
- the disclosure of student health information within the school is limited to the information necessary to provide the student with the necessary services to participate in school.

My signature gives permission for the school administrator and/or school nurse to inform school staff and volunteers of precautions and procedures to protect my child in the classroom. My signature is an informed consent to share this health history information with school staff and volunteers on a need-to-know basis for emergency plans, as determined by the school administrator and/or school nurse.

Parent/Guardian Signature

Date

Doctor's Signature

Date

ALLERGIC TO	
STUDENT NAME	



My signature below confirms that we have informed the school, the principal or their designee of my child's allergies and requested specific actions to be taken in the event of an allergic reaction, as an inducement to you to comply with our request, to relieve Saint Kilian Parish School Saint Kilian Parish, the school staff, the parish staff, and school nurse from liability for injury due to use, misuse, or abuse of the allergy action plan or from any kind of injury which may occur, whether such damage, injury, use, misuse, or abuse be caused by or result from the negligence of Saint Kilian Parish School, Saint Kilian Parish, it's servants, agents, or any other person or persons whatsoever.

I understand that a school nurse is not available during the school day to assess my child's medical condition. I understand that my signature below also gives permission for the principal or designee to contact our physician as necessary regarding the allergy action plan that I am asking the school to follow. I further understand that the school building is also utilized by the Saint Kilian Parish who are not bound by and policies or guidelines promulgated by the Saint Kilian Parish School.

I understand that this release must be notarized unless it is signed at school and witnessed by a member of the school staff.

In witness whereof and intending to be legally bound hereby, we here unto set our hands and seal the ____ day of _____, 20__.

Parent Signature: _____

Witness Signature: _____ (school staff)

This section is for use by Notary if necessary:

Sworn to and subscribed before me, a notary public, this ____ day of _____, 20__.

Notary Public

SEAL

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STUDENT NAME	