Personalized Allergy Action Plan

Date: **[Insert Date]**

Patient Name: **[Patient Name]**

Patient ID: **[Patient ID]**

Allergy Information

- Allergen 1: **[Specify Allergen]**
- Allergen 2: **[Specify Allergen]**
- Allergen 3: **[Specify Allergen]**

Symptoms to Watch For

- [Symptom 1]
- [Symptom 2]
- [Symptom 3]

Action Steps

If Mild Symptoms Occur:

1. Administer [Medication or Treatment]
2. Monitor symptoms for [time duration]

If Severe Symptoms Occur:

1. Administer [Epinephrine/Other Emergency Response]
2. Call emergency services or go to the nearest hospital

Emergency Contacts

Primary Care Physician: **[Physician Name and Contact]**

Emergency Contact: **[Contact Name and Phone Number]**

Notes

[Additional personalized notes or instructions for the patient]

Patient's Signature: ______________________