

Allergy Action Plan

Student Name: [Student's Name]

Date of Birth: [DOB]

School: [School Name]

Grade/Class: [Grade/Class]

Allergies:

- [Allergen 1]
- [Allergen 2]
- [Allergen 3]

Emergency Contacts

Parent/Guardian Name: [Name]

Phone Number: [Phone Number]

Alternate Contact: [Name] - [Phone Number]

Medication Information

Medication Name: [Medication Name]

Dosage: [Dosage]

Administration Instructions: [Instructions]

Signs & Symptoms of Anaphylaxis

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

Emergency Response Plan

1. Call 911 or activate emergency response.
2. Administer epinephrine auto-injector - [specific instructions].
3. Notify parent/guardian immediately.

Teacher/Staff Acknowledgment

This plan has been reviewed by:

Teacher Name: [Teacher's Name]

Date: [Date]

Parent/Guardian Signature

Signature: _____

Date: [Date]