

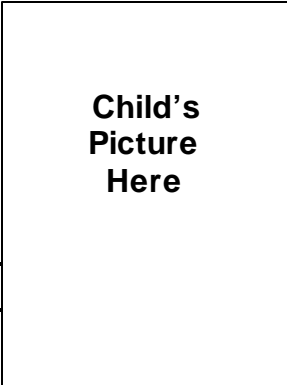


Sunny Hill Preschool Allergy Action Plan

Student's Name: _____ D.O.B: _____

ALLERGY TO: _____

Is this child asthmatic? ? No ? Yes If Yes, HIGH risk for severe reaction



Child's
Picture
Here

SIGNS OF AN ALLERGIC REACTION IN THIS CHILD

Systems: Symptoms: (Check most common reactions)

- ? MOUTH itching & swelling of the lips, tongue, or mouth
- ? THROAT* itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- ? SKIN hives, itchy rash, and/or swelling about the face or extremities
- ? GUT nausea, abdominal cramps, vomiting, and/or diarrhea
- ? LUNG* shortness of breath, repetitive coughing, and/or wheezing
- ? HEART* "thready" pulse, "passing-out"

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

ACTION FOR MINOR REACTION

1. If only symptom(s) are: _____, give _____
medication/dose/route

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION

1. If ingestion/sting is suspected and/or symptom(s) are: _____,
give _____ **IMMEDIATELY!**
medication/dose/route

2. Contact Rescue Squad (Call 911 - ask for advanced life support)

3. Contact Parents / Guardians

Parent's Signature _____ Date _____

Parent's Signature _____ Date _____

Doctor's Signature _____ Date _____

(the prescription label on an Epi Pen will be accepted in lieu of a Doctor's Signature)

Parent/Guardian Emergency Contact Information

1st Contact

Parent/Guardian Name _____

at the following numbers:

Cellular Phone:
Work Phone:
Home Phone:
Alternate Phone:

2nd Contact

Parent/Guardian Name _____

at the following numbers:

Cellular Phone:
Work Phone:
Home Phone:
Alternate Phone:

Who should we contact with questions about your child's allergy? _____

ADDITIONAL EMERGENCY CONTACTS

3rd Contact

Name _____

Relation to Child _____
at the following numbers:

Cellular Phone:
Work Phone:
Home Phone:
Alternate Phone:

4th Contact

Name _____

Relation to Child _____
at the following numbers:

Cellular Phone:
Work Phone:
Home Phone:
Alternate Phone:

5th Contact

Name _____

Relation to Child _____
at the following numbers:

Cellular Phone:
Work Phone:
Home Phone:
Alternate Phone:

Physician Contact Information

Name of Doctor: _____

Hospital or Medical Practice: _____

Phone Number: _____

Address: _____

**Additional Important Information
About This Child's Allergy:**