CLEARVIEW CHILDREN'S CENTER

ClearView ALLERGY ACTION PLAN

ALLERGY TO: ____

Student's Name ____

Please attach child's picture to the top right corner of this form.

Asthmatic: Yes* ☐ No ☐ *High risk for severe reaction **Weight**: ____ lbs. **D.O.B**.: __/__/__

∴ SIGNS OF AN ALLERGIC REACTION

Systems	Symptoms*
MOUTH	Itching and swelling of the lips, tongue or mouth
THROAT	Itching and/or a sense of tightness in the throat, hoarseness or hacking cough
SKIN	Hives, itchy rash and/or swelling about the face or extremities
GASTROINTESTINAL	Nausea, abdominal cramps, vomiting and/or diarrhea
LUNG	Shortness of breath, repetitive coughing and/or wheezing
HEART	"Thready" pulse, unconsciousness or "passing out"

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

∴ ACTION FOR MINOR REACTION

If only symptom(s) are: ____

____

Then call:

1. Mother ________________________, 2. Father ______________________, or emergency contact person.

3. Doctor _________________________ at __________________________.

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

∴ ACTION FOR MAJOR REACTION

If ingestion is suspected and/or symptoms(s) are: ______________________________________,

give ____ IMMEDIATELY!

(medication/dose/route)

Then call:

1. Rescue Squad (ask for advanced life support)
2. Mother ________________________, Father ______________________, or emergency contact person.
3. Doctor _________________________ at __________________________.

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent's Signature ______________________________________ **Date** ____________________________

Doctor's Signature ______________________________________ **Date** ____________________________