ALLERGY ACTION PLAN

Child's Name _____ D.O.B. ___/___/___

Allergy_____ Is child Asthmatic [ ]Yes [ ] No

Please give a list of allergic reaction's child may have and what staff should look for:

STEPS FOR STAFF TO FOLLOW IF ABOVE SYMPTOMS OCCUR:

Call parent/guardian: _____
Phone #

Call Emergency Contact _____
Phone #

_____ __/__/__
Parent's Signature Date

_____ __/__/__
Physician's Signature Date