



Allergy Action Plan (CA Education Code Section 49423)

Student Name: _____ DOB: _____ Grade: _____

Student has Allergy(ies) to: _____

<p style="text-align: center;">MILD SYMPTOMS For <u>ANY</u> of the Following</p> <ul style="list-style-type: none"> • NOSE: Itchy/Runny, Sneezing • MOUTH: Itchy Feeling • SKIN: Few Hives, Mild Itch • GUT: Mild Nausea, Upset Stomach 	<p style="text-align: center;">WHAT TO DO For <u>MILD</u> Symptoms</p> <ol style="list-style-type: none"> 1. Give Antihistamine, if Prescribed 2. Stay with Student, Watch Closely, Notify Parents/Guardians 3. Symptoms Increase, GIVE EPINEPHRINE
<p style="text-align: center;">ANAPHYLAXIS & SEVERE SYMPTOMS For <u>ANY</u> of the Following</p> <div style="border: 2px solid red; padding: 5px; margin-bottom: 10px;"> <input type="checkbox"/> SPECIAL CONSIDERATION: If this box is checked, student has extremely severe allergy. For MILD symptoms, GIVE EPINEPHRINE. </div> <ul style="list-style-type: none"> • LUNGS: Short of Breath, Wheezing, Coughing • HEART: Pale, Blue, Faint, Weak Pulse, Dizzy • THROAT: Tight, Hoarse, Trouble Breathing/Swallowing • MOUTH: Swelling of Tongue/Lips • SKIN: Many Hives, Widespread Redness Over Body • GUT: Repetitive Vomiting, Severe Diarrhea • OTHER: Feeling of 'Doom,' Confusion, Anxiety, Agitation • COMBINATION: Two or More Mild Symptoms 	<p style="text-align: center;">WHAT TO DO For <u>SEVERE</u> Symptoms</p> <ol style="list-style-type: none"> 1. GIVE EPINEPHRINE! 2. CALL 911! 3. Stay With Student, Watch Closely, Notify Parents/Guardians 4. Give Other Medications, if Prescribed <ul style="list-style-type: none"> • Antihistamine • Inhaler/Bronchodilator

MEDICATION(S) & AUTHORIZATION

Medication (Type/Brand)	Dose	Carry on Person (Y/N)*

* If checked, student has been instructed by Physician/HCP in self-administration and may carry & personally administer the medication(s).

Parent/Guardian Signature	Parent/Guardian Phone Number	Date
Physician/HCP Signature	Physician/HCP Phone Number	Date



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