

# ACTION PLAN FOR ALLERGIC REACTIONS

Child's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Is allergic to \_\_\_\_\_

(i.e. Food-ingestion and/or exposure, Bee stings etc. )

**Symptoms of an allergic reaction may include: (check all that apply)**

- |  |  |                                    |  |
|--|--|------------------------------------|--|
| <input type="checkbox"/> Trouble breathing | <input type="checkbox"/> Wheezing/Cough    | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vomiting      |
| <input type="checkbox"/> Throat tightening | <input type="checkbox"/> Swelling          | <input type="checkbox"/> Fainting  | <input type="checkbox"/> Eye Puffiness |
| <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> Abdominal Pain    | <input type="checkbox"/> Hives     | <input type="checkbox"/> Itchiness     |
| <input type="checkbox"/> Nausea            | <input type="checkbox"/> Skin Rash/Redness | <input type="checkbox"/> Sneezing  |  |

OTHER: \_\_\_\_\_

**EMERGENCY ACTION (if necessary):** \_\_\_\_\_

**TREATMENT: (Please be specific and detailed)**

Name of Medicine(s) \_\_\_\_\_ Dosage \_\_\_\_\_

\_\_\_\_\_ Dosage \_\_\_\_\_

When to Administer \_\_\_\_\_

Side Effects of Treatment \_\_\_\_\_

Consequences of Non-Treatment \_\_\_\_\_

I give \_\_\_\_\_ my permission to instruct the staff of Plowshares Child Care in the specifics  
(PARENT/GUARDIAN(S) NAME)  
regarding his/her child's \_\_\_\_\_ allergy/health condition treatment and the side effects of  
that treatment. (CHILD'S NAME)

Physician Name (**print**) \_\_\_\_\_ Tel# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Allergist Name (**print**) \_\_\_\_\_ Tel# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Additional Information / Instructions:**

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**Call Parent(s) / Guardian(s) with any questions or concerns.**

**Parent/Guardian** \_\_\_\_\_ **Relation** \_\_\_\_\_

**HOME TEL#** \_\_\_\_\_ **WORK #** \_\_\_\_\_ **CELL#** \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_ **Relation** \_\_\_\_\_

**HOME TEL#** \_\_\_\_\_ **WORK #** \_\_\_\_\_ **CELL#** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Parent/Guardian**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Parent/Guardian**