

Constellation Schools Madison Community Elementary

Allergy Action Plan

"The Right Choice for Parents and a Real Chance for Children"

Student 5 Name.		Grade	Allergic to:	
Asthmatic: yes*	no (* Higher risk for severe rea	action)		
This child last had an alle	rgic reaction to		on (date)	that presented as:
	SIGNS OF AN AI	LERGIC R	EACTION	
System MOUTH THROAT SKIN GUT LUNGS HEART	Symptoms ITCHING AND SWELLING OF LII ITCHING AND OR TIGHTNESS IN HIVES, ITCHY RASH, AND/OR SV NAUSEA, ABDOMINAL CRAMPS SHORTNESS OF BREATH, REPET "THREADY" PULSE, "PASSING O	THE THROA VELLING OF , VOMITING ITIVE COUG	T, HOARSENESS AND COU THE FACE OR EXTREMITE AND/OR DIARRHEA	
	MINOR	REACTIO	ON	
If symptoms are:				
1. Give(Medicati	ion/Dose/Route of Administration – as	directed on t	the attached Medication Red	quest Form)
2. Then notify pare If symptoms are:	nt or other emergency contact. MAJOR	REACTIO	ON	
If symptoms are:	MAJOR			AMATONATEL VI
If symptoms are:	MAJOR			MMEDIATELY!
If symptoms are:				MMEDIATELY! est Form)
If symptoms are: 1. Give(Medication (s)/2. Call 911.	MAJOR			MMEDIATELY! est Form)
If symptoms are: 1. Give(Medication (s)/ 2. Call 911. 3. Notify parents, or eme	MAJOR Dose/ Route of Administration – as d	irected on the	Itached Medication Requ	
If symptoms are: 1. Give	MAJOR Dose/ Route of Administration – as d rgency contacts and physician.	irected on the	I e attached Medication Requi	MMEDIATELY! est Form)
If symptoms are: 1. Give	MAJOR Dose/ Route of Administration – as d rgency contacts and physician. re:	irected on the	I e attached Medication Requi	::
If symptoms are: 1. Give	MAJOR Dose/ Route of Administration – as designed contacts and physician. re:	irected on the	e attached Medication Requi	:: ::
If symptoms are: 1. Give (Medication (s)/ 2. Call 911. 3. Notify parents, or eme Physician's Signature Parent Signature: Emergency Contact In Name	MAJOR Dose/ Route of Administration – as d rgency contacts and physician. re:	irected on the	attached Medication Requiperation and Date Date utionship	o: o:
If symptoms are: 1. Give	MAJOR Dose/ Route of Administration – as d rgency contacts and physician. re:	irected on the	I e attached Medication Requirements Date Date ationship Cell Phone:	:: ::
If symptoms are: 1. Give	MAJOR Dose/ Route of Administration – as desired and physician. re:	irected on the	tionship Cell Phone:	:: ::

2015 West 95th Street, Cleveland, Ohio 44102

The completed Allergy Action Plan will be on file with the school nurse and a copy will be given to your child's teachers, as necessary.

www.constellationschools.com