



**Constellation Schools**  
**Madison Community Elementary**

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

**Allergy Action Plan**

Student's Name: \_\_\_\_\_ Grade \_\_\_\_\_ Allergic to: \_\_\_\_\_

Asthmatic: \_\_\_\_ yes\* \_\_\_\_ no (\* Higher risk for severe reaction)

This child last had an allergic reaction to \_\_\_\_\_ on (date) \_\_\_\_\_ that presented as:

**SIGNS OF AN ALLERGIC REACTION**

System

MOUTH  
THROAT  
SKIN  
GUT  
LUNGS  
HEART

Symptoms

ITCHING AND SWELLING OF LIPS, TONGUE, MOUTH  
ITCHING AND OR TIGHTNESS IN THE THROAT, HOARSENESS AND COUGH  
HIVES, ITCHY RASH, AND/OR SWELLING OF THE FACE OR EXTREMITIES  
NAUSEA, ABDOMINAL CRAMPS, VOMITING AND/OR DIARRHEA  
SHORTNESS OF BREATH, REPETITIVE COUGHING AND/OR WHEEZING  
"THREADY" PULSE, "PASSING OUT"

**MINOR REACTION**

If symptoms are:

\_\_\_\_\_

1. Give \_\_\_\_\_  
(Medication/Dose/Route of Administration – as directed on the attached Medication Request Form)
2. Then notify parent or other emergency contact.

**MAJOR REACTION**

If symptoms are:

\_\_\_\_\_

1. Give \_\_\_\_\_ IMMEDIATELY!  
(Medication (s)/ Dose/ Route of Administration – as directed on the attached Medication Request Form)
2. **Call 911.**
3. Notify parents, or emergency contacts and physician.

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Emergency Contact Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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.