

2021-22 ALLERGY ACTION PLAN

Health Room Fax #: (704) 368-1078

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PARENT

		Parent's Names:		
Last:		Father Cell:		
DOB:	Grade:	Mother Cell:		
PARENT SIGNATURE:				DATE:
Emergency Contact Name: (other than parent)		Emergency Contact	Number:	

TO BE COMPLETED BY PHYSICIAN

ALLERGIC TO:

ASTHMA:

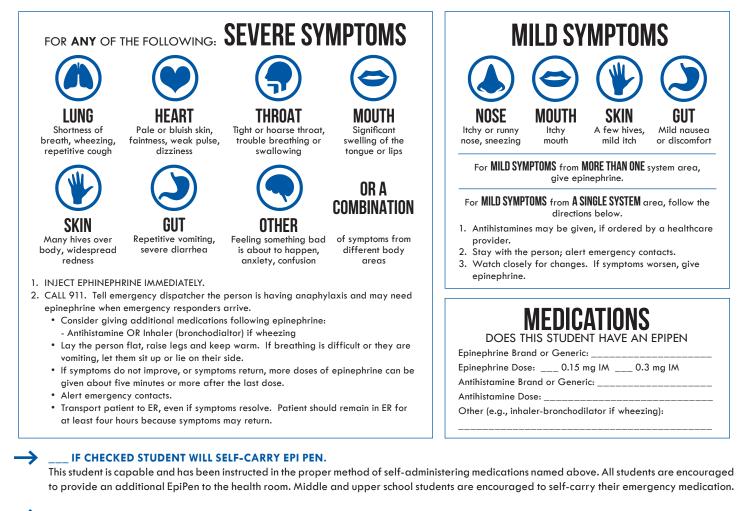
_ YES (higher risk for a severe reaction) ____ NO

NOTE: Do not depend on antihistamines or inhalers (bronchodialators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _

THEREFORE: _____ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

__ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.



 PHYSICIAN SIGNATURE:
 DATE:

 PHYSICIAN NAME PRINTED:
 PHONE: