



NOTICE OF ALLERGY
2020/2021 School Year

Child's Name: _____

Allergy to: _____ (list one allergy per form please)

Student's birthday: _____ Student's teacher: _____

Is the child asthmatic? Yes No

Action Plan

1. If ingestion/sting/reaction is suspected/known, give _____
(**medication/dose/route**)
and _____ immediately!

2. Call 911

3. Call Mother: _____ alt # _____ Call Father: _____ alt # _____
(or call emergency contacts listed below)

4. Call Dr. _____ at _____
Phone # _____

Emergency Contacts:

1. _____ Relation: _____ Phone: _____

2. _____ Relation: _____ Phone: _____

Parent's signature: _____ date: _____

Doctor's signature _____ date: _____

Doctor's recommendations (to be completed by physician ONLY):

Is this allergy (**circle all that apply**) airborne / ingested / per instance (stings, bites, etc.)

Symptoms: (please check all that could apply)

____ Mouth--	itching & swelling of the lips, tongue, or mouth
____ Throat--	itching and/or a sense of tightness in the throat, hoarseness, cough
____ Skin--	hives, itchy rash, and/or swelling about the face or extremities
____ Abdomen--	nausea, abdominal cramps, vomiting, and/or diarrhea
____ Lung--	shortness of breath, repetitive coughing, and/or wheezing
____ Heart--	"thready" pulse, passing out