ASTHMA / ALLERGY ACTION PLAN

(If your child does not have asthma or an allergy, please fill out his/her name and X out the page)

Child's Name: _________________________________ D.O.B. ______________

Allergy to: _________________________________

Asthmatic: ____ No ____ Yes, high risk for severe reaction

***********Signs of an allergic reaction*************

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

**symptoms can potentially progress to a life threatening situation

ACTION FOR MINOR REACTION

1. If the only symptom(s) are: ____,

give ____.
(medication/dose/route)

Then call:
2. Parents or emergency contact.
3. Dr. ___________________________ at (phone) ________________________.

If condition does not improve in 10 minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION

1. If the symptom(s) are: ____,

give ____IMMEDIATELY!!!!
(medication/dose/route)

Then call:
2. 911 and ask for advanced life support – DO NOT HESITATE TO CALL
3. Parents or emergency contact.
4. Dr. ___________________________________ at (phone)__________________________.

Guardian's Signature__________________________ Date _______________________

Doctor's Signature ___________________________ Date _________________________