Student Allergy Action Plan

Student Name: _____

Date of Birth: _____

Grade/Teacher: _____

Allergy Trigger(s): _____

Emergency Contact Information

Parent/Guardian Name: _____ Phone: _____

Secondary Contact Name: _____ Phone: _____

Symptoms and Required Actions

If a student has a MILD reaction (itchy mouth, few hives, mild nausea):

Action: _____

Medication/Dosage: _____

If a student has a SEVERE reaction (swelling, wheezing, difficulty swallowing, fainting):

Action: 1. Administer Epinephrine immediately. 2. Call 911. 3. Contact Parents.

Epinephrine Brand/Dosage: _____

Physician Authorization

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

Medical Clearance for Return to School

Date: _____

To the Administration of: _____ (School Name)

This letter is to certify that _____ (Student Name) has been under my care following an allergic reaction that occurred on _____ (Date).

The student has been evaluated and is now medically stable. They are cleared to return to all school activities, including physical education and cafeteria attendance, effective _____ (Return Date).

Special Instructions/Restrictions:

_____

_____

Authorized Healthcare Provider Name: _____

Clinic/Hospital Stamp or Signature: _____

Contact Number: _____