



ALLERGY ACTION PLAN

PARENTS: Please provide the following information if your child has an allergy besides medicine:

STUDENT'S NAME: _____ D.O.B. _____

ALLERGY TRIGGER

TYPE OF CONTACT

(i.e., skin contact, inhalation, ingestion)

Warning signs of an allergic episode: _____

Treatment/Special Instructions: _____

Note: If medicine is indicated, it can only be administered in accordance with the school policy as noted in the manual.

Comments: _____

Parent Signature _____ Date: _____