Our Lady Help of Christians Academy

Allergy Action Plan

***2019-2020* Academic Year**

Part I: to be completed by parent or guardian

Date:_____

Name of Student: _____ Grade:_____

Person(s) to notify in case of an acute allergy episode:

_____ _____
Name and relationship to student *telephone*

_____ _____
Name and relationship to student *telephone*

Physician:

_____ _____
Name of physician (first and last) PLEASE PRINT *telephone*

_____
Physician street address *City, State, ZIP*

Part II: to be completed by physician

Signs of an acute allergy episode:

1. _____
2. _____
3. _____

Steps to take, including medications used and dosages:

1. _____
2. _____

List of allergens likely to trigger acute allergy episodes.

1. _____
2. _____
3. _____

Signed _____ _____
Physician Signature *Date*

Form Revised 06-2016