Allergy Action Plan

Child's Full Name: _____

Date of Birth: _____

Parent/Guardian Name(s): _____

Phone Number: _____

Allergy To (list all known allergens):

_____

Type of Reaction(s):

[ ] Rash [ ] Hives [ ] Swelling [ ] Difficulty Breathing [ ] Vomiting

[ ] Other (please describe): _____

Date of Last Reaction: _____

Has the child been prescribed an EpiPen? [ ] Yes [ ] No

If yes, is it provided to the daycare? [ ] Yes [ ] No

Daily Allergy Management Instructions:

_____

Emergency Action Steps (please be specific):

_____

Medication to be administered in an emergency:

_____

Physician's Name: _____

Phone Number: _____

Parent/Guardian Signature: _____ Date: _____

Physician Signature (if required): _____ Date: _____