Allergy Alert and Action Plan

Child's Name: ___________________________________

Date of Birth: _______________

*An **Allergy Action Plan** must be completed for ALL allergies. This plan must be signed by your child's physician stating the specific precautions, reactions and medicinal procedures we should follow in case of accidental contact or digestion. Please update this information yearly, or as new allergies develop.*

ALLERGIES (Circle)

Peanuts	Milk	Shellfish
Soy	Wheat	Tree Nuts
Fish	Pollen	Mold
Dust Mites	Pets	Honeybees/Hornets/Wasps/ Yellow Jackets
Fire Ants	Penicillin	Sulfates
OTHER:		

Symptoms/Reactions to Watch For:

	Name	Symptoms/Reactions
Allergy #1		
Allergy #2		
Allergy #3		
Allergy #4		

Treatment Needed Upon Contact or Digestion:

	Name	Treatment Needed
Allergy #1		
Allergy #2		
Allergy #3		
Allergy #4		

The child named above has been tested and found to be allergic to the foods/medications/environments/insects indicated.

Physician's Printed Name		Hospital Affiliation
Address	Phone Number	Fax Number
Physician's Signature		Date

In order to ensure the safety of our children with allergies, we will post your child's picture with specific allergy information in the kitchen and classroom(s). Please sign below indicating permission to post allergy information.

Guardian Signature: ____ Date:_____________________

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