INDIVIDUALIZED ACTION PLAN
(Allergy, Asthma or Food Allergy)

Allergy to:

____

Student's Name:______________________________ DOB: __________________

*SIGNS OF AN ALLERGIC REACTION: (Include symptoms)

*ACTION FOR ALLERGIC REACTION (Please list all steps needed, in the order they should be taken)
For example, if your child is allergic to peanuts and requires the use of an Epipen and an emergency room visit, please specify.

EMERGENCY CONTACTS IF REACTION OCCURS:

Parent's Signature:_______________________________Date: __________________

Teacher's Signature ______________________________Date: _________________

Director's Signature ______________________________Date: _________________