Our Lady Help of Christians Academy

Allergy Action Plan

2024-2025 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