

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: _____