Strongsville City Schools

Allergy Action Plan

To the parent/guardian of _____

School _____ Grade _____

According to our records your child is allergic to _____

We need to know what type of reaction your child has if exposed to the above allergen. Please check below the reaction, which most closely describes the symptoms, experienced by your child.

1.	A local reaction which includes swelling, redness, and possible itching around the area of exposure/ingestion/sting.	**YES**	**NO**
2.	A delayed reaction which can occur from two hours to three weeks after the exposure/ingestion/sting. Symptoms include fever, rash, swelling and joint pain.	**YES**	**NO**
3.	After the exposure/ingestion/sting the child immediately experiences wheezing, swelling, hives, difficulty breathing/swallowing, vomiting, faintness, cyanosis, loss of consciousness. **This is a life-threatening reaction!**	**YES**	**NO**

Does your child require medication at the time of the exposure/ingestion/sting?

YES **NO** Name of medication_____

Do you plan to have medication available at school? _____

Will your child sit at the **nut free** table during lunch? _____

Medication Administration forms and **Authorization for Student Possession and Use of an Epinephrine Autoinjector** forms are available from the school clinic, and must be completed before any medication can be administered at school.

_____ _____

Parent/Guardian signature Date

_____

Parent/Guardian emergency telephone number(s)

Please complete this form and return it to the clinic nurse

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