Emergency Allergy Action Plan

Child's Name: _____

Child's Birthday: _____

Primary Address: _____

Parent Name: _____

Parent Phone Number: _____

Parent Name: _____

Parent Phone Number: _____

Known Allergies: _____

Warning Symptoms and Signs: _____

_____

Treatment Plan:

❑ Call 911	❑ Inject Epi-Pen
❑ Administer Medication	❑ Other:

Medication: _____

Signature: _____ Date: _____