

ALLERGY ACTION PLAN

IMPORTANT!

▽ If your child has any allergies requiring the possible use of medications, please complete and return this form to Valley Brook with your Physician's orders for the administration of appropriate medication or Epi Pen / Auvi-Q.

73 East Valley Brook Road
Long Valley, NJ 07853
Phone: (908) 876-3840
Fax: (908) 876-0182
info@ValleyBrookSchool.com

Student Name: _____ Birthdate: _____

ALLERGIES - List all known

Describe reaction and management of the reaction

Food Allergies (list)

Medication Allergies (list)

Other Allergies (list) - include asthma, insect stings, hay fever, animal dander, etc.

BELOW IS TO BE FILLED OUT AND SIGNED BY YOUR CHILD'S PHYSICIAN

ACTION FOR MINOR REACTION - to be administered by authorized school personnel.

If only symptoms are _____ give _____
medication/dose

Then call:

1. Parent 1 _____, Parent 2 _____, or emergency contacts.
Name, Phone Name, Phone

2. Dr. _____
Name, Phone

If condition does not improve within 10 minutes, follow the steps for Major Reaction below.

ACTION FOR MAJOR REACTION

If ingestion is suspected and/or symptoms are _____

give _____ **IMMEDIATELY!**

Then Call:

1. Rescue Squad (ask for advanced life support). Do Not hesitate to call Rescue Squad!

2. Parent 1 _____, Parent 2 _____, or emergency contacts.
Name, Phone Name, Phone

3. Dr. _____
Name, Phone

Physician's Signature _____ Date _____

Parent's Signature _____ **Date** _____