

Allergy: Plan of Action

Child's Name: _____ Age: _____ Weight: _____

Please describe your child's allergy:

In the event of an allergic reaction, what steps would you like us to take: (Is your child able to identify what is happening, and do they understand their treatment plan)

Please list any activities that your child should be excluded from:

Please list any foods they are not allowed to eat:

Are there any medications that need to be left on site, in the event of an allergic reaction:

Please list your physician's name and telephone number:

Contact person and phone number, in the event of a reaction:

I hear by given permission for Zion Lutheran Staff to administer treatment to _____, in accordance with the above treatment plan.
(child's name)

(Parent/Guardian signature)

(Today's date)