Open arms
LUTHERAN - CHILD - DEVELOPMENT - CENTER
4000 Roswell Road, N.E. • Atlanta, Georgia 30342
404-256-1330

Allergy Action Plan

Student's Name:_____**D.O.B:**_____

Food Allergy _____

_____

Medical or Environmental Allergy _____

_____

NOTE: If your child requires an altered food menu, you MUST provide a doctor's note for our school's file.

Physician's Name _____

Physician's Contact Information _____

Will the allergy or allergic reaction, when active, substantially limit one or more major activities?
YES _____ **NO** _____
If yes, describe the limitation

_____

_____

Signs of allergic reaction to watch for include: _____

_____

_____

_____

Emergency Services should be called if: _____

Medication to be given: _____
Medical Form must be completed by parent

If parents/guardians cannot be reached, child will be transported to nearest medical facility.

I give permission for Open Arms to follow this plan of care prescribed by the physician. Staff may not vary from the instructions. I will provide any updates by the physician every 6 months hereafter.

I release and forever discharge Open Arms employees from any and all liability arising in law or in equity as a result of an employees' performing with reasonable care actions in conformance with the Allergy Action Plan.

_____ _____
Signature of Parent/Guardian Date

_____
Parent/Guardian Contact Phone Number