



Boys & Girls Clubs of Central Minnesota/KIDSTOP

Allergy Action Plan

Child: _____

Site: _____

Allergy:

Symptoms of the Allergy:

Triggers:

Avoidance Techniques:

Procedures for Responding:

Medication (If needed):

Primary Doctor _____

Phone _____

Parent/Guardian Signature: _____

Date: _____

Staff Sign Off: Allergy List

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