Allergy Action Plan (fill out one form for each allergy)

Child's Name:_____ **D.O.B:**_____ Classroom:_____

ALLERGY TO:_____

Asthmatic ? ❒ No ❒ Yes (Higher risk for severe reaction)

STEP 1: TREATMENT

Medication to be determined by physician authorizing treatment.

SYMPTOMS:	**GIVE CHECKED MEDICATION**		
• If a food allergen has been ingested, but ***no symptoms***:	❒ No medication	❒ Antihistamine	❒ EpiPen
• **Mouth** - Itching, tingling, or swelling of lips, tongue, mouth	❒ No medication	❒ Antihistamine	❒ EpiPen
• **Skin** - Hives, itchy rash, swelling of the face or extremities	❒ No medication	❒ Antihistamine	❒ EpiPen
• **Gut** - Nausea, abdominal cramps, vomiting, diarrhea	❒ No medication	❒ Antihistamine	❒ EpiPen
• **Throat*** - Tightening of throat, hoarseness, hacking cough	❒ No medication	❒ Antihistamine	❒ EpiPen
• **Lung*** - Shortness of breath, repetitive coughing, wheezing	❒ No medication	❒ Antihistamine	❒ EpiPen
• **Heart*** - Thready pulse, low BP, fainting, pale, blueness	❒ No medication	❒ Antihistamine	❒ EpiPen
• **Other*** _____	❒ No medication	❒ Antihistamine	❒ EpiPen
• If **reaction is progressing (several of the above areas affected)**	❒ No medication	❒ Antihistamine	❒ EpiPen

*** Potentially life-threatening.** **The severity of symptoms can quickly change.**

DOSAGE (Must fill out medication consent form also)

Epinephrine : ❒ EpiPen ❒ EpiPen Jr. ❒ Other_____
(see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

STEP 2: EMERGENCY CALLS

1. **CALL 911** as soon as Epi-Pen is administered.
2. Call parent/guardian or emergency contacts.

I, (parent's name)_____, attest that the above information is true and accurate. I am responsible for providing the Girls Club with up to date information and medications necessary for my child's health and safety.

Parent Signature:_____

Date:

I, (physician's name)_____, authorize the child's parent to train the staff at the Girls Club of Greenfield on how to administer these emergency medications.

Physician Signature:_____

Date:_____

Individual Health Care Plan

Plan must be renewed annually or when child's condition changes

Plan was created by: Physician or Licensed Practitioner **Plan maintained by:** Leanne Du Pree

Name of child: Date:
Any change to the child's Health Care Plan? **YES** (indicate changes below) **NO** (updated physician/parental signatures required)
Name of chronic health care condition: □ Asthma □ Allergy Please specify:_____ □ Seizure Disorder □ Diabetes □ Other (Be specific)_____
Potential side effects of treatment:
Potential consequences if treatment is not administered:
Name of educators that received training addressing the medical condition *(filled out by agency if required)*:

Name of Physician (please print):_____

Physician Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medicationfor use as needed.

Age of child:_____ Date of birth:_____ Back-up medication received? YES NO

Parent/Guardian Signature:_____ Date:_____

Administrator's Signature:_____ Date:_____