

Dear Parents:

**Re: School Allergy Action Plan:**

We understand that your child \_\_\_\_\_ has an allergy. This condition can be serious and may require emergency treatment while at school. It is important that the school has up-to-date information about the management of your child's allergy condition.

Complete the attached School Allergy Action Plan (in consultation with your child's medical practitioner). The school reserves the right to call an ambulance if your child is having a uncontrolled allergy attack or difficulty breathing.

Please help us to responsibly care for your child while at school by completing, signing, and returning this Allergy Action Plan as soon as possible.

Thank you for your cooperation in this matter.

Yours sincerely,

The AAS Medical Staff

**AAS ALLERGY ACTION PLAN**

**School Year**

\_\_\_\_\_

**STUDENT'S NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_

**Allergy to:**  Bee/Insect Sting       \_\_\_\_\_       Food      (specify) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_       Other      (specify) \_\_\_\_\_

**Asthmatic?**  Yes  No      **High risk for severe reaction** \_\_\_\_\_

**If pollen grass, or dust allergies, circle time of year these occur:** \_ Fall, \_ Winter, \_ Spring, \_ Summer

**SIGNS OF ALLERGIC REACTION (check all that apply to your student)**

- |   |  |
|---|--|
| <input type="checkbox"/> Swelling or redness at sting site              | <input type="checkbox"/> Rash            |
| <input type="checkbox"/> Itching/swelling lips, tongue, or mouth/throat | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Trouble breathing, swallowing, talking         | <input type="checkbox"/> Hives           |
| <input type="checkbox"/> Wheezing, hoarseness, coughing                 | <input type="checkbox"/> Itchy skin      |
| <input type="checkbox"/> Other (specify) _____                          |  |

**I would rate the severity of my child's allergy as: (please circle one)**

Not severe      1      2      3      4      5      Severe

<b>TREATMENT</b>	
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**I request that the following medication be kept in health office and be administered as ordered.**

**Parent must supply medication. If emergency medications indicated on this plan are not provided, an ambulance will be called as needed.**

1. Give Medication: \_\_\_\_\_ Dose: \_\_\_\_\_  
Route: \_\_\_\_\_

If symptoms are: \_\_\_\_\_

2. Give Medication: \_\_\_\_\_ Dose: \_\_\_\_\_  
Route: \_\_\_\_\_

If symptoms are: \_\_\_\_\_

3. **Call Ambulance (if Epi given or if reaction severe or if emergency meds not available).**

4. Call parents or emergency contacts as designated below.

**Student Signature:** \_\_\_\_\_

**Date:**

\_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:**

**Phone Numbers:** 1) \_\_\_\_\_ 2) \_\_\_\_\_

\_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

**Date:**

**Phone Numbers:** 1) \_\_\_\_\_ 2) \_\_\_\_\_

\_\_\_\_\_

**Does your student carry own epi-pen with them? (Circle One) YES NO**

**HEALTH OFFICE**

Tel: + 7 495 231 4488, ext. 3911

Email: [health.office@aas.ru](mailto:health.office@aas.ru)

**If your child is going on a field trip and has an Epi-pen available at school, what would you like done?**

Notify parent of field trip, and send epi-pen from school with student who has been trained on proper use of Epi-Pen.

Notify parent of field trip, school medical staff to train ONE designated school employee to administer Epi-Pen if needed. Send Epi-Pen on field trip with designated employee.