ALLERGY ACTION PLAN

Primary Campus
28 Vo Truong Toan St.,
An Phu, Dist. 2, HCMC

Secondary Campus
1 Xuan Thuy St., Thao Dien,
Dist. 2, HCMC

Tel: (84-28) 3898 9100
Fax: (84-28) 3898 9382
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www.ishcmc.com

STUDENT'S PERSONAL DETAILS

Student's Name: . . . . **Date of Birth:** . . . . . /. . . . . /. . . . .

Allergic to: . . . .

Asthmatic: Yes (Higher risk for severe reaction) No

DAILY MEDICATIONS FOR ALLERGY:

Name of medication: . . . . **Dosage:** . . . .

Has s/he ever had a severe allergic reaction or anaphylactic shock? Yes No

Please tick the symptoms that your child has experienced:

Mild Symptoms

- ☐ Itchy Mouth
- ☐ Cough and sneezing
- ☐ Itchy eyes/swollen eyelids
- ☐ Nausea/vomiting
- ☐ Flush/pallor
- ☐ Skin hives/rash

Sereve Symptoms

- ☐ Swollen lips/tongue/throat
- ☐ Difficulty breathing/wheezing
- ☐ Abdominal cramps
- ☐ Heavy sweating
- ☐ Oedema

Others:

EMERGENCY MEDICATION FOR ALLERGY:

Name of medication: . . . . Dosage: . . . .

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EMERGENCY TREATMENT IN THE SCHOOL CLINIC:

- I agree to inform the school of any medications my child requires, and any changes in prescription, in writing to the school clinic.
- According to school policy, all medications must be stored in the school clinic unless agreed by school for the child to carry their own.
- Please notify me if my child has symptoms of allergic reaction at school
- In the event of an allergic reaction, I agree for my son/daughter to receive the treatment as described above.
- I agree to pay all expenses incurred for any medical treatment necessary.

☐ I agree to the above.

Parents Signature. . . . . **Name** . . . . **Date:** . . . . . ./ . . . . . ./. . . . . .

ISHCMC has a policy for Allergies and Anaphylaxis. Epi Pens are stored in the school clinic and will be given by injection to any student with clinical symptoms of Anaphylaxis. If you have any questions please contact the clinic during school hours, phone: +84 (28) 3898 9100 ext. 2105, or email: Nurse@ishcmc.edu.vn