HEALTH OFFICE
Tel: + 7 495 231 4488, ext. 3911
Email: health.office@aas.ru

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

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)

[ ] Swelling or redness at sting site
[ ] Itching/swelling lips, tongue, or mouth/throat
[ ] Trouble breathing, swallowing, talking
[ ] Wheezing, hoarseness, coughing
[ ] Other (specify) _____

[ ] Rash
[ ] Nausea/Vomiting
[ ] Hives
[ ] Itchy skin

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

Not severe 1 2 3 4 5 Severe

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.

Treatment

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: _____

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