Community Education & Recreation Department
A Division of Mankato Area Public Schools

INDIVIDUAL ALLERGY HEALTH PLAN / EMERGENCY CARE PLAN

Child's Name: ______________________________ Birth Date: ____________

Program Name/Site: ______________________________ Grade: ____________

* *

1. My child is allergic to:______________________________
2. Reaction occurs from: ☐ingestion ☐contact ☐inhalation ☐insect sting
3. My child has had a life threatening, anaphylactic reaction to this allergen: ☐YES ☐NO
4. Does your child also have asthma? ☐YES (*Higher risk for severe allergic reaction*) ☐NO

SIGNS OF AN ALLERGIC REACTION INCLUDE:
(Please check symptoms most common to your child.)

☐MOUTH ☐SKIN ☐GUT ☐THROAT ☐LUNGS ☐HEART ☐OTHER

MOUTH	SKIN	GUT	THROAT	LUNGS	HEART	OTHER
itching & swelling of the lips, tongue, or mouth	hives over body, widespread redness, itchy	nausea, abdominal cramps, vomiting, diarrhea	tight or hoarse throat, trouble breathing or swallowing	shortness of breath, wheezing repetitive cough	pale or bluish skin, faintness, weak pulse, dizziness	feeling something bad is about to happen, anxiety, confusion

5. History of reaction (date of last reaction / signs & symptoms of reaction): ______________________________
____
6. Avoidance strategies used at home: ______________________________
7. Does your child recognize these signs and symptoms? ☐YES ☐NO
8. Will your child require a rescue medication to be given during program hours? ☐YES ☐NO
9. Health Care Provider Name: ______________________ Phone #: ______________
10. <u>Emergency Contacts</u> (*list in order of who to call first*)

Name: ____________________ Relationship:__________ Phone:__________Phone:__________

Name: ____________________ Relationship:__________ Phone:__________Phone:__________

<u>**OVER**</u>

Child's Name:_____

CER ALLERGY ACTION / EMERGENCY PLAN:

If child has an epinephrine auto-injector for a bee sting allergy, it will be immediately given if stung*

1. Give prescribed medications if available. If symptoms do not improve, or symptoms return, additional dose of epinephrine can be given (if ordered by a licensed prescriber and authorized by parent/guardian).
2. Call 911. Tell emergency dispatcher the person may be having anaphylaxis.
3. Lay the person flat, raise legs, and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side. Calm and reassure student.
4. Contact parents/guardian.
5. Emergency transportation to hospital is recommended for further monitoring.

(The Consent Form for Administration of Emergency Allergy Medication for an epinephrine auto-injector must be completed and signed by the health care provider and parent.)

CER MANAGEMENT PLAN / PARENT/GUARDIAN AUTHORIZATION

❑ **No epinephrine auto-injector at program.** Follow the above CER Allergy Action/Emergency Plan.

❑ **Epinephrine auto-injector to be administered as ordered**. The epinephrine auto-injector must be properly labeled for the student.

1. I understand that this plan may be shared with all program staff working directly with my child.
2. I will contact the program if a change in the current plan is needed.
3. I will provide this medication in the original, properly labeled pharmacy container to program site (see criteria for proper labeling on Consent For for Administration of Emergency Allergy Medication, which must be provided with this form if epinephrine is to be given).

Parent/Guardian Signature _____ **Date** _____