Allergy Management Plan
Southmont Schools

Plan Created For: _____

Student Name: _____ **Date of Birth:** _____
Parent/Guardian: _____ **Today's Date:** _____
Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
Emergency Contact: _____ **Phone:** _____
Primary Healthcare Provider: _____ **Phone:** _____
Allergist: _____ **Phone:** _____

1. Does your child have a diagnosis of an allergy from a healthcare provider? ☐ **No** ☐ **Yes**

2. History and Current Status

A. What is your child allergic to?
- ☐ Peanuts
- ☐ Eggs
- ☐ Milk
- ☐ Latex
- ☐ Soy
- ☐ Other _____
- ☐ Insect Stings
- ☐ Fish/Shellfish
- ☐ Chemicals _____
- ☐ Vapors _____
- ☐ Tree Nuts (walnuts, pecans, etc.)

B. Age of child when allergy first discovered: _____
C. How many times has student had a reaction?
☐ Never ☐ Once ☐ More than once, explain:
_____
D. Explain past reaction(s): _____
E. Symptoms: _____
F. Food allergy reactions: ☐ Same ☐ Better ☐ Worse

3. Trigger and Symptoms

A. What are the early signs and symptoms of your child's allergic reaction? *(Be specific; include things the student might say.)* _____
_____

B. How does your child communicate his/her symptom(s)? _____

C. How quickly do symptoms appear after exposure to food(s)? _____ secs. _____ mins. _____ hrs. _____ days

D. Please check the symptoms that your child has experienced in the past:

Skin:	☐ Hives	☐ Itching	☐ Rash	☐ Flushing	☐ Swelling (*face, arms, hands, legs)*
Mouth:	☐ Itching	☐ Swelling *(lips, tongue, mouth)*			
Abdominal:	☐ Nausea	☐ Cramps	☐ Vomiting	☐ Diarrhea	
Throat:	☐ Itching	☐ Tightness	☐ Hoarseness	☐ Cough	
Lungs:	☐ Shortness of breath		☐ Repetitive Cough		☐ Wheezing
Heart:	☐ Weak pulse	☐ Loss of consciousness			

4. Treatment

A. How have past reactions been treated? _____
B. How well did your child respond to treatment? _____
C. Was there an emergency room visit? ☐ No ☐ Yes, explain: _____
D. Was the student admitted to the hospital? ☐ No ☐ Yes, explain: _____
E. What treatment or medication has your healthcare provider recommended for use in an allergic reaction? _____
_____
F. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes
G. Have you used the treatment or medication? ☐ No ☐ Yes
H. Please describe any side effects or problems your child had in using the suggested treatment: _____
_____

Please go to Page 2.

5. Self Care

A. Is your child able to monitor and prevent their own exposures? ☐ No ☐ Yes

B. Does your child:

1. Know what foods to avoid? ☐ No ☐ Yes
2. Ask about food ingredients? ☐ No ☐ Yes
3. Read and understand food labels? ☐ No ☐ Yes
4. Tell an adult immediately after an exposure? ☐ No ☐ Yes
5. Wear a medical alert bracelet, necklace or watchband? ☐ No ☐ Yes
6. Tell peers and adults about the allergy? ☐ No ☐ Yes
7. Firmly refuse a problem food? ☐ No ☐ Yes

C. Does your child know how to use emergency medication? ☐ No ☐ Yes

D. Has your child ever administered their own emergency medication? ☐ No ☐ Yes

6. Minor Reaction Plan

A. If the only symptom(s) is/are: _____,

then give *(medication/dose/route)*: _____

B. Call parent/guardian *(name)*: _____ at *(number)*: _____

or Emergency Contact *(name)*: _____ at *(number)*: _____

If condition worsens, or does not improve within 10 minutes, follow steps for Major Reaction (below).

7. Major Reaction Plan

A. If ingestion is suspected and/or symptom(s) is/are: _____,

then give *(medication/dose/route)*: _____ **IMMEDIATELY!**

B. Call 911 (inform of severe allergic reaction/food allergy ingestion) and provide symptoms. **DO NOT HESITATE!**

C. Call parent/guardian *(name)*: _____ at *(number)*: _____

or Emergency Contact *(name)*: _____ at *(number)*: _____

D. Comments/special instructions: _____

_____

8. Additional Information/Instructions/Notes

Please provide any additional information/instructions/notes that may be needed to most effectively respond to the individual needs of your child: _____

_____

_____

_____

9. Required Signatures

I give permission to the school nurse or other designated staff members of my child's school to perform and carry out the Allergy Management Plan as outlined by this document. I also consent to the release of information contained in this Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I give consent for school personnel to exchange information with my child's physician for the benefit of his/her health care.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Physician's Signature **Date**