



# INDIVIDUAL ALLERGY HEALTH PLAN/EMERGENCY CARE PLAN

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Program Name/Site: \_\_\_\_\_ Grade: \_\_\_\_\_

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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 \_\_\_



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, fairness, 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. Emergency Contacts: (list in order of who to call first)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

OVER

**CE ALLERGY ACTION/EMERGENCY PLAN**

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

1. Give prescribed medications if available. If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given (if ordered by a licensed prescriber and authorized by parent/guardian).
2. Call 911. Tell the 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)*

**CE MANAGEMENT PLAN/PARENT/GUARDIAN AUTHORIZATION**

- No epinephrine auto-injector at program.** Follow the above CE 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 the program site (see criteria for proper labeling on [Consent Form for Administration of Emergency Allergy Medication](#), which must be provided with this form if epinephrine is to be given).

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_