

ALLERGY FORMS

This packet includes the following forms:

I. Allergy Care Plan

II. Allergy Action Plan

These two forms are required for children who have allergy. Please fill out and return both to school. If there are questions, please contact the Haynes Health Office.

Sudbury Public Schools Allergy Care Plan

Student Name _____ School Year: _____

Parents Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

1. List triggers which cause an allergic reaction. (i.e. foods, environmental, insect)

2. Briefly describe your child's allergic symptoms.

3. How do you treat an allergic episode once it has started?

___ antihistamine ___ epi-pen ___ other

Briefly describe: _____

4. Does your child experience any side effects from this medication/treatment?

5. Does your child understand his/her allergy management?

___ yes ___ no

6. Approximately how frequently does your child have an allergic episode?

7. Please outline the treatment plan for your child if he/she has an allergic reaction at school.

Parent Signature: _____ Date: _____

Allergy Action Plan

Paste child's
picture here

Student's Name _____ D.O.B. _____ Teacher _____

Allergy to _____

Asthmatic Yes * No * High risk for severe reaction

Signs of an Allergic Reaction Include:

Systems:

- MOUTH
- THROAT*
- SKIN
- GUT
- LUNG *
- HEART*

Symptoms:

itching and swelling of the lips, tongue, or mouth
itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
hives, itchy rash, and/or swelling about the face or extremities
nausea, abdominal cramps, vomiting, and/or diarrhea
shortness of breath, repetitive coughing, and/or wheezing
"thready" pulse, "passing out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION:

1. If the student is showing any signs or symptoms of an allergic reaction, contact the school nurse immediately.
2. Administer _____ immediately!
3. CALL 911 (Request Epinephrine)

4. Call Mother: _____ Father: _____
Work _____ Work _____
Cell _____ Cell _____

Call Emergency Contacts:

Name _____ Phone _____
Name _____ Phone _____

Call Doctor _____ Phone _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911

This information will be shared with appropriate staff. Allergen free table at lunch: Yes ___ No ___

Physician Signature _____ Date _____

Parent Signature _____ Date _____

Nurse Signature _____ Date _____