

PRESCHOOL - SEVERE ALLERGY CARE PLAN

place picture here

Nurse only, to fill out this side.

Name _____

Allergy _____

Asthmatic: Yes **** High risk for severe reaction if asthmatic**
No

Signs Of An Allergic Reaction Include:

Systems:

*Mouth

*Throat

*Skin

*Gut

*Lung

*Heart

Symptoms:

itching & swelling of lips, tongue, or mouth

itching and/or sense of tightness in throat, hoarseness, 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!***

ALL STAFF

If ingestion or contact is suspected immediately put in place the emergency action plan.

EMERGENCY ACTION PLAN:

1. If ingestion or contact is suspected, give: (medication order)

2. CALL 911

3. NOTIFY PARENT/GUARDIAN:

Students' Home telephone #: _____

Mother/guardian name: _____ phone #'s _____

Father/guardian name: _____ phone #'s _____

CLASSROOM TEACHERS

Parent/guardians must be notified at least one week in advance of any lessons or field trips that involve working with, ingesting, or purchasing **ANY FOODS**. After discussion with parent/guardian a plan must be in place to assure the activity is safe for the allergic student.

Field trips

Plans must include:

1. Supervision of food choices when off campus.
2. Plans for administration of emergency medication if needed

DO NOT HESITATE TO ADMINISTER MEDICATION AND CALL 911

PRESCHOOL - SEVERE ALLERGY Parent/Guardian Questionnaire

Parents/Guardians – fill out this side only.

Student Name: _____ Date of Birth: _____
Hospital Preferred: _____ Doctor: _____
Telephone: _____

Please complete this form and return it to the nurse so that she may give appropriate instructions to school personnel concerning your child's food allergy. Contact the nurse with any questions or concerns.

List all items your child is allergic to. **Please be specific.** _____

Reaction can occur by (check all that apply): ingestion contact inhalation

Does your child's physician recommend special accommodations when eating? Yes No

Specify: _____

Check all signs usually present During Allergy Attack:

Difficulty breathing rash nausea cough flushed or pale color

Itchy throat tight throat difficulty swallowing Loss of consciousness

swelling: How much? /Where _____

other symptoms _____

Has hospitalization been needed in the past for allergies? Yes No

If yes, please explain (when)

What medications have been ordered by your physician to be administered in the event of accidental ingestion?

List name, amount, and frequency: _____

Is your child fully aware of his/her allergy, methods of avoidance and proper treatment? Yes No

Does your child have asthma? Yes No

***ADVISE THE NURSE IMMEDIATELY OF CHANGE IN DOSE OR TYPE OF MEDICATION.**

The Usual Treatment For A Severe Allergic Reaction Is To:

- Administer prescribed medication per written doctor's order.
- Call 911 / EMS.
- **Notify parents/guardians:**

Students' Home telephone #: _____

Mother/guardian name: _____ phone #'s _____

Father/guardian name: _____ phone #'s _____

- Observe the student for inadequate breathing, signs of shock, unusual swelling. Provide comfort and support.
- Additional Instructions: _____

I give permission for the above information and a picture of my child to be shared with appropriate staff:

Signature of Parent/Guardian

Date

Signature of Nurse/Date