



Plan of Care for **Allergies** (©AYS Inc.)

Child's Name: _____ **Date of Birth:** _____ **Age:** _____
AYS Program: _____

Physician child sees for Allergies:

Name (please print) Phone Number

Medications your child uses for prevention of his/her allergy:

(* Please list medications for Emergency treatment of an allergic reaction on next page.)

Name of Medication(s)	Dosage	Time(s) of day given

Would medication(s) need to be given during normal program hours?YES/NO

Would medication(s) need to be given during non-school days?YES/NO

If **yes** to either question, an AYS permission slip, completed by your child's doctor is required. Have you returned this permission slip to the AYS director?YES/NO

Identify the things that start an allergy episode (check any that apply to your child)

- Animals Bee/insect sting Chalk dust Change in temperature
 Dust mites Exercise Latex Molds
 Pollens Respiratory infections Smoke Strong odors
 Food _____
 Other _____

Control of the Child Care Environment

List any environmental control measures, premedications &/or dietary restrictions that your child needs to avoid an allergy episode. _____

Outside activity & field trips (List the medications that must accompany your child on these activities)

Name	Dosage	When to use

YOUR child's symptoms of an allergic reaction: (Please circle those that apply)

Mouth/throat: itching & swelling of lips, tongue, mouth, throat; cough; hoarseness; difficulty swallowing

Skin: hives; itchy rash; swelling; flushed or unusually pale skin color

Lung: difficulty breathing; shortness of breath; coughing; wheezing

Gut: abdominal cramps; nausea; vomiting; diarrhea

Heart: fainting; pulse is hard to detect

Others: _____

The usual procedure at AYS for a child having an allergy episode:

1. If the above symptoms occur, administer the medication(s) listed below.
2. Have the child lie down.
3. Do not give the child anything by mouth, except emergency medications.
4. Monitor ABC's.
5. If **severe allergic symptoms** develop (hives all over the body; severe swelling of the eyes, skin, tongue, or throat; wheezing; nausea; vomiting; diarrhea; fainting) call for **Emergency Medical Services**.
6. Notify parent/guardian of any allergic symptoms, whether mild or severe.
7. Any special instructions from parent or physician: _____

EMERGENCY allergy medication(s):

Name	Amount	When to use

AYS requested **Epi-pen** from parents: ___ YES ___ NO

Parents provided AYS with **Epi-pen**: ___ YES ___ NO

If you have provided AYS with an **Epi-pen**, an AYS permission slip completed by your doctor is required. Have you returned this permission slip to the AYS director? YES/NO

Review of above information & signatures for this school year in AYS:

 Parent/Guardian Signature

 AYS Program Director's Signature

 Date

 Date

Review of above information & signatures for the next school year in AYS:

 Parent/Guardian Signature

 AYS Program Directors' Signature

 Date

 Date