



### Plan of Care for Allergies

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 the current year in AYS:**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
AYS Program Director's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**Review of above information & signatures for the subsequent year in AYS:**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
AYS Program Director's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date