Kids Go Further
AYS
AT YOUR SCHOOL

Plan of Care for Allergies

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

AYS Program: _____ **School Year:** _____

Physician child sees for Allergies:

_____ _____

Name (please print) (Physician's 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 Medication Consent form, completed by your child's doctor is required.

Have you returned this form 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 and/or dietary restrictions that your child needs in order to avoid an allergy episode. _____

_____

_____

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

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

4/02; rev. 6/02, rev. 4/03, rev. 11/3/09

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

☐ **Mouth/throat:** itching/swelling of lips, tongue, mouth, throat; cough; hoarseness; dissculty swallowing

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

☐ **Lung:** dissculty 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.

Any special instructions from parent or physician: _____

_____

_____

EMERGENCY Allergy Medication(s):

Name of Medication	Amount	When to use

AYS requested **Epi-pen** from parents ..... ☐ YES ☐ NO

Parents provided AYS with **Epi-pen** ..... ☐ YES ☐ NO

If you provided AYS with an **Epi-pen**, an AYS Medication Consent form completed by your doctor is required.

Have you returned this form to the AYS director? ..... ☐ YES ☐ NO

Review of above information and signatures for the _____ school year in AYS *(1st year)*:

_____ _____

Parent/Guardian Signature AYS Program Director's Signature

_____ _____

Date Date

Review of above information and signatures for the _____ school year in AYS *(2nd year)*:

_____ _____

Parent/Guardian Signature AYS Program Director's Signature

_____ _____