Kids Go Further
AYS
AT YOUR SCHOOL

Plan of Care for Allergies

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

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

Please list the name and phone number of the physician your child sees for allergies below:

_____ _____

Name (please print) Physician's Phone Number

Does your child take prescription medication for the prevention or treatment of their allergy? ☐ YES* ☐ NO

If your child participated in an outside activity or field trip would they be required to take any medications with them for the prevention of an allergic reaction? ☐ YES* ☐ NO

(*If you answered **yes** to either of the above questions please list the medications your child takes for prevention/ treatment of allergies below)

Name of Medication(s)	Dosage	Time(s) of Day Given

Would any of the above medication(s) need to be given during normal program hours? ☐ YES ☐ NO

Would any of the above medication(s) need to be given during extended program hours? ☐ YES ☐ NO

If you answered **yes** to either question, please be aware that an AYS Medication Consent form will need to be completed by your child's doctor and provided to AYS.

Have you provided an AYS Medication Consent form to AYS staff? ☐ YES ☐ NO

In order to assist AYS in the care of your child please identify the things that could cause an allergic reaction for your child (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(s) _____
☐ Other _____

Control of the Program Environment:

Please list any steps, measures, restrictions or anything that your child could require, to avoid experiencing an allergic reaction. Ex.: Having your child sit at a separate table due to a peanut allergy._____

_____

_____

_____

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Please indicate your child's symptoms of an allergic reaction: (Please check all 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 a suspected allergic reaction is as follows: If the above symptoms occur, administer the medication(s) listed previously. Have the child lie down. Do not give the child anything by mouth, except emergency medications. Monitor airway, breathing and circulation. 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. Notify parent/guardian of any allergic symptoms, whether mild or severe. If there are any special instructions in addition to the steps listed above please list them below:

_____

_____

_____

_____

<u>Emergency Allergy Medication</u>:

Does your child require carrying an EPI-Pen or other emergency medication? ☐ YES ☐ NO
Did you indicate on the previous page that medication information? ☐ YES ☐ NO
Did you provide AYS with an EPI-Pen or other emergency medication? ☐ YES ☐ NO

Review of above information and signatures for the _____ school year in AYS.

_____ _____
Parent/Guardian Signature AYS Program Director's Signature

_____ _____
Date Date

Review of above information and signatures for the _____ school year in AYS.

_____ _____
Parent/Guardian Signature AYS Program Director's Signature

_____ _____
Date Date

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