(Office Use Only)
Date Rec'd: _____

Reviewed: _____

(Office Use Only)
Attach
child's
picture
here

Pequea Preschool
Individualized Allergy Plan

Child's Name: _____ Date of Birth: _____ School Year: _____

Teacher/Class: _____

Weight: _____ lbs. _____ kg.

Allergy to: _____

Does this allergy include: (**circle ALL that apply**) Ingestion Touching the allergen Air-born allergen particles Insect bite/sting

Has your child ever had an epinephrine (epi-pen) injection before? ❍ Yes ❍ No

STEP 1: TREATMENT

Symptoms:

Give checked medication**

**(to be determined by physician authorizing treatment)

• If a food allergen has been ingested, but NO SYMPTOMS	❍ Epinephrine ❍ Antihistamine
• Mouth - Itching, tingling or swelling of lips, mouth or tongue	❍ Epinephrine ❍ Antihistamine
• Skin - Hives, itchy rash, swelling of face or extremities	❍ Epinephrine ❍ Antihistamine
• Gut - Nausea, abdominal cramps, vomiting, diarrhea	❍ Epinephrine ❍ Antihistamine
• Throat - Tightening of throat, hoarseness, hacking cough	❍ Epinephrine ❍ Antihistamine
• Lungs - Shortness of breath, repetitive coughing, wheezing	❍ Epinephrine ❍ Antihistamine
• Heart - Thready pulse, fainting, pale, blueness	❍ Epinephrine ❍ Antihistamine
• Other:	❍ Epinephrine ❍ Antihistamine
• If reaction is progressing (several areas may be affected) give:	❍ Epinephrine ❍ Antihistamine

_____ (Parent initials needed) - Epinephrine pens and antihistamines are to be provided by the parents and will be stored in marked medical containers, with a copy of this plan included, in the child's classroom.

DOSAGE

Epinephrine (to be injected intramuscularly) Describe brand/dosage with specifics.

_____

Antihistamine: Give: _____
(Medication/dose/route)

Other: Give: _____
(Medication/dose/route)

Does your child wear a medic alert tag? ❍ Yes ❍ No

Continue on reverse side

STEP 2: EMERGENCY CALLS

_____ (Parent initials needed) - Consent to **call 911** while administering appropriate medication, **BEFORE** calling parents.

_____ (Parent initials needed) - Consent for EMS to transport to nearest hospital **OR** designate your choice: _____

Doctor Information

Doctor's Name: _____

Doctor's Phone Number: _____

Parent Contact Information

Emergency contact numbers for each parent (include home/cell/work):

Mother's name: _____

Home: _____

Work: _____

Cell: _____

Father's name: _____

Home: _____

Work: _____

Cell: _____

What necessary arrangements need to be made for field trips?

Please list any other issues or special precautions that you feel are important to your child's safety and care during the school day. Be very specific:

Parent's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____