# Plan of Care for Allergies

**Student's Name:_____ Date of Birth:_____Age:____**
**Program Site:_____ School Year_____**

**Does your student take prescription medication for the prevention/ treatment of allergies? ___Yes ___No**

**If your student participated in an outside activity or field trip would it be required to take any medication for the prevention of an allergic reaction? ___ Yes ___No**

**Medications your student uses for the prevention of allergies:**

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

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

**Would any of the above medication(s) need to be given during program hours? ___Yes* ___No**

**If yes, a medication form must be filled out by the physician and returned **before** your child can receive any medication.* Medication must be in original container with correct dosage instructions.

**Identify the things that could start an allergy episode** (check any that apply student)

___Animals ___Bee/Insect Sting ___Change in temp ___Dust mites

___Exercise ___Latex ___Molds ___Pollens

___Smoke ___Strong odors ___Respiratory Infections

___Foods*_____

___Other_____

**Must have a physician signed Medical Statement for Children with Special Dietary Needs on file for the program's nutrition program.*

**Control of the Program environment:**

List any environmental control measures, pre-medications &/or dietary restrictions that your youth needs to avoid an allergy episode: _____
_____

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

| Name of Medication | Dosage | When to use |
|---|---|---|
| | | |
| | | |
| | | |

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

**____Mouth/throat:** itching & swelling of lips, tongue, mouth, throat, cough, hoarseness, or difficulty swallowing

**____Skin:** hives, itchy rash, swelling, or flushes or unusually pale skin color

**____Lung:** difficulty breathing, shortness of breath, coughing, or wheezing

**____Gut:** abdominal cramps, nausea, vomiting or diarrhea

**____Heart:** fainting, or pulse is hard to detect

**____Other:**_____

**The usual procedures at CYC/CCP for youth having a suspected allergy episode:**

1. If the <u>above symptoms</u> occur, administer the medication(s) <u>listed below.</u>
2. Have the student lie down.
3. Do not give the student anything by mouth, except emergency medications.
4. Monitor airway, breathing and circulation.
5. If **<u>severe allergic symptoms</u>** develop (hives all over the body, severe swelling of the eyes, skin, tongue or throat, wheezing, nausea, vomiting, diarrhea or fainting) a call for **Emergency Medical Services will be made.**
6. Parent/legal guardian will be notified of any allergic symptoms, whether mild or severe.
7. Any special instructions from parent/legal guardian or physician:_____

_____

**EMERGENCY Allergy Medication(s):**

| Name of Medication | Dosage | When to use |
|---|---|---|
| | | |
| | | |
| | | |

**Did you provide CYC/CCP with an <u>Epi-Pen or other emergency medication</u>? ____Yes* ____No**

**If you provide the program with an **epi-pen or other emergency medication,** a medication form **must** be filled out **<u>before</u>** your child can receive any medication.*

_____ _____

*Parent/ Legal Guardian Signature & Date* *Program Director Signature & Date*