

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

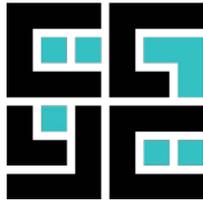
___ Foods* _____

___ 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 above symptoms occur, administer the medication(s) listed below.
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 **severe allergic symptoms** 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 Epi-Pen or other emergency medication? Yes* No

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

Parent/ Legal Guardian Signature & Date

Program Director Signature & Date