Chester County Technical College High School
Emergency Allergy Action Plan

Dear Parents/Guardian,
In order to provide your child with the best possible health care please have your physician fill out this questionnaire at your next scheduled appointment. When leaving medication at school, all medications and supplies must in their original container, labeled with your child's name and date of birth. Medications and supplies are returned to the parent at the end of the school year.

Name: _____ DOB: _____

Identify the things that start an allergy episode: (Check all that apply)

☐Animals ☐Bee/Insect Sting ☐Chalk Dust ☐Dust Mites

☐Latex ☐Molds ☐Pollens ☐Seasonal

☐Food: _____ ☐Other: _____

My child has the following reaction(s) when exposed to an allergen: (Check all that apply)

☐Abdominal Cramps ☐Itching all over the body ☐Swelling of the lips tongue, throat

☐Wheezing ☐Difficulty Breathing ☐Skin Flushed ☐Thickened speech

☐Extreme Weakness ☐Bluish color of skin or lips ☐Other_____

☐Swelling/ Redness ☐Hoarseness ☐Dizziness ☐Nausea ☐Vomiting

Comments: _____

Control of Student Environment (List any environmental control measures, pre- medications, and/or dietary restrictions that the child needs to prevent an allergy episode.)

_____

_____

Daily Medication Plan for Allergy

	Name	Dosage	Amount	When to use
1	_____	_____	_____	_____
2	_____	_____	_____	_____

Outside Activities and Field Trips

The following medications must accompany child when participating in outside activity and field trips:

	Name	Dosage	Amount	When to Use
1	_____	_____	_____	_____
2	_____	_____	_____	_____

Disaster Planning: Please consider that in a disaster your child may not have access to medical supplies for up to 72 hours. The health office encourages students with special medical considerations to keep a 72-hour supply of medication and supplies at school for use in the event of a disaster. Please label your child's medication and supplies with student's name and date of birth. All medications and supplies are returned to the parent at the end of the school year.

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Steps to take during an allergy episode:

1. If the following symptoms occur, give the medications listed below.

_____**Mouth/Throat:** itching & swelling of lips, tongue, mouth, throat; throat tightness; hoarseness; cough

_____**Skin:** hives; itchy rash; swelling

_____**Gut:** nausea; abdominal cramps; vomiting; diarrhea

_____**Lung:** shortness of breath; coughing; wheezing

_____**Heart:** pulse is hard to detect; "passing out"

Emergency Allergy Medications:

Administer _____ _____ _____
Name Dosage Route

2. If no improvement after _____minutes administer:

_____ _____ _____
Name Dosage Route

3. **Activate Emergency Medical Services (911)**

4. Contact the child's parent/guardian.

This information will be shared with emergency services if activated.

_____ _____
Physician's Signature **Date**

_____ _____
Parent/Guardian's Signature **Date**