Warlingham School

Wide Horizons
High Aspirations

Allergy & Anaphylaxis Health Care Plan

Please complete this form in Capital letters and black ink

Student Name: Date of Birth:	Tutor Group: GP:
Emergency Contact Name: Relationship to student:	Daytime Tel No: Mobile No:
Other Emergency Contact Name: Relationship to Student:	Daytime Tel No: Mobile No:
ALLERGY TO: This means (student name) …….. must avoid ALL substances which contain or may contain:	ADDITIONAL INFORMATION (e.g. Asthma, Eczema and OTHER health conditions)

Symptoms – *please tick all those that apply when your child has a reaction:*

Alterations of heart rate	Difficulty in speaking	Loss of Smell/taste	Stomach ache
Anxiety/panic	Feeling faint	Nausea	Feeling weak
Blocked nose	Floppy limbs	Painful sinuses	Swelling of throat
Blotchy skin	Headaches	Prickly eyes	Swollen eyes
Constipation	Hives	Red eyes	Swollen lips
Coughing	Itchy eyes	Runny nose	Tingling of lips and face following eating
Dark areas under eyes	Itchy nose	Sense of impending doom	Vomiting
Diarrhoea	Itchy mouth/ tongue and/throat	Sneezing	Watery eyes
Difficulty in breathing	Floppy limbs	Sore mouth/ throat/swollen larynx	Wheeziness

Medication Requirements (*for medication taken at home*)

Name of Medication	Dosage & time taken? (e.g. Antihistamine x 1 a day)

Does your son/daughter carry emergency medication? Please detail below:

Do they carry an inhaler? _____

Do they carry an Epipen or Jext? _____

Other medication carried _____

Where is this kept? _____

Should your son/daughter require emergency medication to be held at school, we ask that this be sent into Student Services clearly labelled with your child's name, in its original packaging as dispensed by the pharmacist with a visible expiry date.

Please note that any medication must be accompanied by an "Authorisation for Medication" form. This is available from Student Services or via the school website.

We would ask that you make a note of the expiry date of any medication sent into school and replace when necessary. All medications must be collected by the last day of Summer term or will be disposed of.

Does GP, Hospital or Paediatrician monitor your child's treatment? If yes, please use the space below to inform us of who this is:

Name & Address:

Please tick your preferred Action Plan for your son/daughter below:

☐ **WARLINGHAM SCHOOL PLAN –**

Steps to take:
First instance for mild symptoms, which may require antihistamines or inhalers.
(for example rash, headache, vomiting, itchy, tongue & swelling)
My son/daughter is to take the following medication:

_____

If reaction becomes moderate to severe - This may require inhalers, antihistamines and/or adrenaline.
(*E.g. difficulty in breathing, facial swelling, coughs and choking, wheezing, pallor, blue lips, fainting unconsciousness this is known as ANAPHYLAXIS and is an extreme emergency).*
Please give my son/daughter the following medication if they experience moderate to severe reactions:

_____

- Student will be placed in the recovery position (safe airway position).
- An immediate administration of adrenaline into the upper outer thigh by a first aider may be required and/or taking an inhaler/antihistamine may also be necessary
- A 2nd preloaded adrenaline injection will be given if available and the condition of student has not improved.

N.B. We will always telephone an ambulance in cases of severe allergic reactions, as these are medical emergencies.

OR

☐ **PARENT/GUARDIANS CARE PLAN FOR STUDENT** – *please complete your own plan below*:

***Please choose one option below:**

☐*a) My child is able to take responsibility for the self-administration of his/her medication and is able to carry his/her medication on their person at school. I do not wish Student Services to hold spare medication. (Only in the case of students who do not need an Epipen).

☐*b) My child will carry their own medication but I would also like Student Services to hold a spare.

Home/School Communication Terms – please sign the parental agreement section below

- ✓ Please notify me if my child regularly has allergy complications whilst at school.
- ✓ Please notify me if my child has received emergency First Aid.
- ✓ I authorise school staff to assist my child with taking medication if they require help.
- ✓ I will notify the school immediately if there are any changes to these instructions.
- ✓ I agree to the staff taking responsibility for and administrating medication in the event of an allergic reaction taking place.

PARENTAL AGREEMENT & ANNUAL RENEWAL
When requirements change significantly, complete a new Individual Care Plan and share with all involved. A copy of the original plan will be sent to their parent/guardian at the start of a new academic year. This will allow them to make any changes or to confirm the plan should stay the same. Once the parent / guardian have reviewed this, the school should place a new dated copy (regardless of whether or not there has been any changes) on file and update their systems.
☐ This plan remains in effect for the period _____ to _____ school year without change. ***Or*** ☐ We the parent/ guardian of _____Have made changes to our son/daughter's Diabetic Care Plan and these changes should be implemented immediately. Parent/guardian:_____ Date: _____ Staff in charge of Care Plan Process :_____Date:_____

For office use only

CP created by:	Date:
Copy sent to parent/guardian to complete	Date:
Signed copy received from parent/guardian	Date:
Entered on SIMS	Date:
Is a Risk Assessment required?	YES/ NO
Completed by:	Date: