

Allergy & Anaphylaxis Care Plan

Student Name: Tutor Group: Date of Birth: Address:	Photo of Student: <div style="border: 1px solid black; width: 100%; height: 100%;"></div>
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Emergency Contact Name: Relationship to student:	Daytime Tel No: Mobile No:
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GP: Address: Tel No:	Other Emergency Contact Name: Relationship to Student: Tel No:
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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)
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Symptoms – please tick all those that apply when your child has a reaction:

Ear/Nose/Throat Symptoms:	Eye Symptoms:	Airway Symptoms:	Digestion:	Other:
Runny nose	Watery	Wheeziness	Swollen lips	Blotchy skin
Blocked nose	Itchy	Difficulty in breathing	Tingling of lips and face following eating	Feeling faint
Itchy nose	Prickly	Coughing	Constipation	Alterations of heart rate
Sneezing	Red	Swelling of throat	Stomach ache	Anxiety/panic
Painful sinuses Headaches	Swollen eyes	Difficulty in speaking	Itchy tongue	Sense of impending doom
Itchy mouth and/or throat Blocked ears.	Allergic 'shiners' (dark areas under the eyes due to blocked sinuses)		Vomiting	Sudden feeling of weakness
Loss of sense of Smell/taste,			Nausea	Hives
Sore mouth/ throat/swollen larynx (voice box),			Diarrhoea	Floppy limbs

Any other not listed above:

Does _____ need/carry emergency medication? Please detail below:

Is this an inhaler? Y/N _____

Name of antihistamine medicine or tablets? _____

Is this an EpiPen or Jext? _____

Where is this kept? _____

If sending medication into Student Services please note that all medication should be clearly labelled, in the original container as dispensed by the pharmacist, expiry dates and instructions for use should be clearly stated. **Please use the form overleaf to send medication into school.**
 We advise parents/guardians to remind their child regularly of the need to refuse any food items, which may be offered to them by other students.

Medication Requirements *(for medication held at school)*

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

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.

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

Name & Address:

Home/School Agreement Terms:

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

Parent/Carer please sign and print your name below:

Signed:

Print Name:

Date: