Somerset Early Childhood Center
ALLERGY Medical Action Plan (MAP)

Child's picture, face only ^

Child's Name: _____ **Date of Birth:** _____

Classroom: PSY PSB PKY PKB KE **Teachers:** _____

- Pages one and two of this MAP are to be completed, signed and dated by both parent(s)/guardians.
- Page three of this MAP is to be completed, signed and dated by the treating physician or licensed prescriber.
- Without signatures from both parents/guardians this MAP is not valid. The parent/guardian is responsible for supplying all medications.

Dear Parent/Guardian:
You indicated on your child's emergency care or physical examination form that he/she has allergic reactions. We need your answers to the following questions in order to provide effective first aid if your child should come in contact with the identified allergen (allergic substance).

Please return this form promptly so that school personnel will be able to provide specific first aid measures for your child.

1. **What has caused your child to have an allergic reaction?** _____

2. **Has your child ever had a severe reaction to an insect sting (Circle type: honeybee, bumblebee, black hornet, yellow hornet, yellow jacket) or a food, or other substance?**
   YES NO

3. **What was the food or substance?**_____

4. **What symptoms did your child experience?** (check all that apply)
   At site of the sting (if applicable) ___Redness ___Swelling
   General body reaction: ___Itching all over ___Hives
   ___Flushing all over ___Difficulty breathing
   ___Weakness ___Nausea/abdominal cramps

5. **How soon after exposure to the allergen did the symptoms occur?** _____

6. **Does your child recognize they are allergic if stung or exposed to the substance that has caused an allergic reaction?** YES NO

7. **If there has been more than one reaction, was the last reaction worse than the previous one?** YES NO

8. **Has the allergy been diagnosed by a doctor?** YES NO

9. **What treatment was recommended?**
   ___ Basic First Aid – ice, rest, observation
   ___ Oral Medication (Name: _____)
   ___ Injectable Medication (Type: _____)

10. **Does the allergy limit the child's participation in any school activities (i.e. recess)** YES NO

Page 2 – To be completed by Parents/Guardians

Contact Information – Parents/Guardians

1. **CALL FIRST**
Name: _____
Relationship: _____
Phone #1 _____
Phone #2 _____

2. TRY SECOND
Name: _____
Relationship: _____
Phone #1 _____
Phone #2 _____

* Please list phone numbers in order of preference to be called

3. CALL THIRD (If a parent/guardian cannot be reached)

Name: _____ Relationship: _____
Address: _____ Phone(s): _____

ALLERGY HISTORY

Has your child ever been given an epinephrine shot for an allergic reaction? YES NO

Does your child have Asthma? YES NO If YES, at a higher risk for severe allergic reaction? YES NO

List all allergic FOODS. If nuts, please specify peanuts, tree nuts or both.

_____
_____

Other foods to avoid: _____

List of different SEVERE ALLERGIES (such as insect stings and latex)

_____
_____

Somerset provides nut-free snacks, but some snacks we serve may be "Processed in a facility that also processes nuts," or "Manufactured on equipment also used for nuts" or similar disclaimers written by manufacturers. Do you serve your child food with these types of allergy disclaimers? YES NO
If NO, parents must supply their child's daily snack. Please initial indicating you agree & understand this policy. _____

- I would like to talk with the director about my child's allergies: YES NO
- I would like epinephrine auto injectors kept in more than one school location. YES NO

I agree to have the information in this plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having severe allergies to better identify needs. I give my permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to give the medication(s), as ordered on page 3 of this MAP, for allergic reactions and to contact the physician/licensed prescriber for clarification of orders, if needed.

Parent Signature _____ Date _____

Parent Signature _____ Date _____

Treating Physician/Licensed Prescriber to Complete Page 3

- I give permission to give Epinephrine immediately for ANY symptom if the allergy was likely eaten. YES NO
- I give permission to give Epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted. YES NO

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/ swallowing
MOUTH: Obstructive swelling (tongue and/or lips
SKIN: Many hives over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling (e.g. eyes, lips)
GUT: Vomiting, crampy pain

→

1. Inject Epinephrine Immediately
2. Call 911
3. Begin monitoring (See Monitoring box below)
4. Give additional medication * (If ordered)
   - Antihistamine
   - Inhaler

* Antihistamines & inhalers are not to be depended upon to treat a severe reaction (Anaphylaxis). USE EPINEPHRINE

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

→

1. GIVE Antihistamine
2. Stay with student, Call parent/guardian
3. If symptoms progress: USE EPINEPHRINE (above)
4. Begin monitoring (See below)

MONITORING: Stay with student; call 911 and parent/guardian. Tell rescue staff that epinephrine was given and the time of administration. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For severe reaction, consider keeping student lying on back with legs raised. Keep head to side if vomiting. Treat child even if parent cannot be reached.

The above protocol meets the medical requirements of this child: YES NO **If NO, additional protocol requirements MUST be attached, and signed/dated by treating physician and child's parents**.

* See Auto-Injector Directions Posted with Action Plans and in the Medication Storage Area. Directions for use are also printed on the medication. Check the expiration date when an Auto-Injector is brought to school.

For Office Use: Epinephrine will expire this school year? YES NO If Yes, when? _____
For Office Use: Location(s) of auto-injector (epinephrine) in the school _____

Authorized **Physician/Licensed Prescriber Order** & **Agreement with Protocol** in this 3-page plan (see page 1)

Epinephrine Dose: ____ 0.15mg Junior Other: _____
Two doses are made available at school. YES NO

Antihistamine Name _____ **Dosage** (please do not give range) _____
Note: liquid is faster acting than pill form.
Other instructions or orders: _____

Physician/Licensed Prescriber Name (Print) _____
Phone number _____ Fax Number _____
Signature _____ Date _____