THE CARTWRIGHT SCHOOL

ALLERGY ACTION PLAN

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This individualized plan identifies the child, reduces exposure to known allergens, and guides staff response. It must be completed by the parent/guardian, the child care facility, and the child's healthcare provider before care begins.

Child's Name		**DOB**	
Parent/ Guardian		**Classroom**	
Address			
Phone		**Plan Date**	

CHILD PHOTO
Attach a current photo for quick identification

ALLERGY INFORMATION

Known allergen(s)	
Typical reaction / severity	
Avoidance and monitoring instructions	
Emergency medication storage location	

EMERGENCY CONTACT INFORMATION *Complete every field*

CONTACT ROLE	NAME / RELATIONSHIP	DAYTIME NUMBER	CELL
Parent/Guardian 1			
Parent/Guardian 2			
Emergency Contact 1			
Emergency Contact 2			

EMERGENCY INSTRUCTION **Even if a parent/guardian cannot be reached, administer the authorized medication and immediately call 911.**

CHILD CARE FACILITY RESPONSIBILITIES *Facility staff should check each item*

- ☐ Prohibit food sharing and maintain an updated allergy list.
- ☐ Observe and monitor the child for signs of a reaction.
- ☐ Send a staff member trained in Medication Administration on off-site activities.
- ☐ Follow proper handwashing procedures.
- ☐ Keep emergency medication immediately available during all activities.
- ☐ Follow the healthcare provider's avoidance and treatment instructions.

PARENT / GUARDIAN RESPONSIBILITIES *Parent/guardian should check each item*

- ☐ Provide complete, current information about the child's known allergies.
- ☐ Maintain a sufficient supply of emergency medication.
- ☐ Review menus and coordinate substitutions with management and/or the cook.
- ☐ Keep all emergency contact information current.
- ☐ Replace medication before its expiration date and follow TCS medication policies.
- ☐ Provide medication instructions and staff training, as needed.

AUTHORIZATION

PARENT / GUARDIAN AUTHORIZATION By signing below, I authorize The Cartwright School to administer the medication(s) prescribed by the child's healthcare provider and supplied by the parent/guardian, as directed on page 2.

Parent/Guardian Signature & Date

Director Signature & Date

HEALTHCARE PROVIDER INSTRUCTIONS

This page must be completed and signed by the child's licensed healthcare professional.

Child's Name _____ **DOB** _____

Please list ALL KNOWN food and environmental allergies:

_____

_____

Is the child ASTHMATIC? ☐ No ☐ Yes (Higher risk for a severe reaction)

TREATMENT DIRECTIONS *Check the medication to give for each symptom*

SYMPTOMS / SIGNS	EPINEPHRINE	ANTIHISTAMINE
INGESTION: Allergen ingested; child is not showing or reporting symptoms.	☐	☐
MOUTH: Itching, tingling, or swelling of lips, tongue, or mouth.	☐	☐
SKIN: Hives, itchy rash, or swelling of the face or extremities.	☐	☐
GUT: Nausea, abdominal cramps, vomiting, or diarrhea.	☐	☐
THROAT*: Difficulty swallowing, hoarseness, or hacking cough.	☐	☐
LUNG*: Shortness of breath, repetitive coughing, or wheezing.	☐	☐
HEART*: Weak or fast pulse, low blood pressure, fainting, pale skin, or blueness.	☐	☐
OTHER:	☐	☐
PROGRESSING: Several areas above are affected.	☐	☐

IMPORTANT Symptoms marked with an asterisk may be life-threatening and can change quickly. Asthma inhalers and antihistamines do not replace epinephrine in anaphylaxis.

APPROVED MEDICATIONS

MEDICATION TYPE	MEDICATION NAME / BRAND	DOSE TO ADMINISTER
Epinephrine		
Antihistamine		
Other		

Attach the manufacturer's instructions or a provider handout explaining how to administer the prescribed epinephrine auto-injector.

EMERGENCY RESPONSE

FOLLOW ALL THREE STEPS 1. CALL 911 whenever epinephrine is administered. 2. Call the parent/guardian and explain that the child was treated and may need additional epinephrine. 3. Stay with the child.

ADDITIONAL PHYSICIAN NOTES

_____

_____

HEALTHCARE PROVIDER AUTHORIZATION

Doctor's Name _____ **Phone** _____

Doctor's Signature _____ **Date** _____

OFFICE USE ONLY

Medication Received _____ **Expiration Date** _____

Storage Location _____ **Staff Review Date** _____