The Cartwright School

1647 Cartwright Road, Missouri City, Texas 77489
Email: tcschool1647@gmail.com Phone/Fax: (281) 437-6300 / 6301
URL: www.thecartwrightschool.com

TCS Allergy Action Plan

(This form must be completed by the childcare facility, parent/guardian, AND your child's healthcare provider)

Child's Name: _____ DOB: _____

Address: _____ Phone #: _____

Emergency Contact Information

Contact(s):	Name / Relationship	Phone Number(s)	
		Daytime Number	Cell
Parent/Guardian **1**			
Parent/Guardian **2**			
Emergency **1**			
Emergency **2**			

*EVEN IF A PARENT/GUARDIAN CANNOT BE REACHED, **DO NOT** HESITATE TO MEDICATE **AND IMMEDIATELY** CALL 911.

The Child Care Facility will: *(Childcare facility will check the following boxes)*

- ☐ Reduce exposure to allergen(s) by no food sharing, keeping an updated list of children with food allergies, etc.
- ☐ Ensure proper handwashing procedures are followed
- ☐ Observe and monitor the child for any signs of allergic reaction(s)
- ☐ Ensure that medication is **immediately** available to administer in case of an allergic reaction (in classroom, playground, field trips, etc.)
- ☐ Ensure that a person trained in Medication Administration accompanies the child on any off-site activity
- ☐ _____

The Parent/Guardian will: *(Parent will check the following boxes)*

- ☐ Ensure the childcare facility has **ANY** and **ALL up-to-date/current** information of child's known allergies
- ☐ Ensure **ALL** contact information is **current** in the event of an emergency
- ☐ Ensure the childcare facility has a sufficient supply of emergency medication
- ☐ Adhere to the policies regarding medication as stated in Operational Policies and replace medication prior to the expiration date
- ☐ Monitor any foods served by the childcare facility by viewing the posted menu and make substitutions or arrangements with management and/or cook, if needed.
- ☐ _____

By signing this document, you authorize the childcare provider to administer the medication(s) prescribed by the child's healthcare physician / provided by the parent/guardian as indicated on page 2 of this form.

_____ _____

Parent/Guardian Signature & Date Director Signature & Date

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THIS PORTION IS TO BE COMPLETED BY THE CHILD'S HEALTHCARE PROFESSIONAL

Child's Name:_____ DOB:_____

Please List **ALL KNOWN** Food Allergies:

_____

_____

Is the child **ASTHMATIC**? ☐ No ☐ Yes (If Yes = Higher Risk for Severe Reaction)

TREATMENT (please check one of the following medications)

Symptoms: The child has ingested a **food allergen**:	**Give this Medication** Epinephrine	Antihistamine
But is ***NOT*** exhibiting or complaining of any symptoms		
Mouth: itching/tingling/swelling of lips, tongue, or mouth ("mouth feels funny")		
Skin: hives / itchy rash/swelling of the face or extremities		
Gut: nausea / abdominal cramps/vomiting/diarrhea		
Throat*: difficulty swallowing ("choking feeling") / hoarseness/hacking cough		
Lung*: shortness of breath ("can't breathe") / repetitive coughing/wheezing		
Heart*: weak or fast pulse / low blood pressure/fainting / pale / blueness		
Other:		
If reaction is progressing (several of the above areas are affected)		

These are potentially life-threatening. Please be mindful that the severity of symptoms can quickly change.

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis (a severe, potentially life-threatening allergic reaction).

APPROVED MEDICATIONS:

Medication Name/Brand		**Dose to Administer**
Epinephrine:		
Antihistamine:		
Other:		

*Please provide additional information (brochure or flyer) on how to successfully administer epinephrine or use an EpiPen.

*Additional Physician Notes:*_____

EMERGENCY CALLS

1) CALL 911 whenever Epinephrine has been administered. **2) Call the parent.** State that an allergic reaction has been treated and additional epinephrine may be needed. **3) Stay with the child.**

Doctor's Name:_____ Phone #:_____

Doctor's Signature: _____ Date:_____