TCS Allergy Action Plan

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

Child’s Name:

Address:

DOB: 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 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 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 posted menu and make substitutions or arrangements with management and/or cook, if needed.

By signing this document, you are hereby authorizing 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

TCS Allergy Action Plan

**THIS PORTION IS TO BE COMPLETED BY THE CHILD’S HEALTH CARE PROFESSIONAL**

Child’s Name: DOB:

Please List **ALL KNOWN** Allergies (Food/Environmental):

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** or has been exposed to an **allergy trigger**: | **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 how to 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: