The Y in Central Maryland

ALLERGY EMERGENCY CARE PLAN

My child _____ does/does not have an allergy.
Child's name (circle one)

Signature required at the bottom for ALL forms. Please *complete all allergy information even if medication is not n*ecessary.

Grade:_____ Age:_____ Date of Birth:_____

Site:_____

Parent/Guardian Name:_____

Cell phone:_____ Work phone:_____ Home phone:_____

Address:_____

To provide assistance to this student experiencing an allergic reaction:

Type of allergy: _____

_____

Identify triggers for allergic reaction:

_____

_____

Possible allergic signs: _____

_____

OTHER CONSIDERATIONS:

_____

_____

_____

ACTIONS TO TAKE (Do This)

Stay calm.

Stay with the child.

Ask someone to contact 911 and/or parent

Are medications at the Y program? Yes/No

Medications on file to treat child:

_____

_____

In order for the Y to administer medication, a completed Medication Administration Authorization Form must be on file.

Other care options: _____

_____

CALL 911 if student has:

Difficulty breathing or noisy breathing
Tightness of chest
Swelling of tongue, eyes, or lips
Swelling/tightness in throat
Difficulty talking and/or hoarse voice
A wheeze or persistent cough
Loss of consciousness and/or collapse
Vomiting, stomach cramps, or diarrhea
Blue discoloration of lips or fingernails
Becomes pale and floppy

Administer CPR if breathing stops! Continue until paramedics arrive!

I give consent for the Y in Central Maryland authorities to take appropriate action for the safety and welfare of my child. I give my consent for the Y in Central Maryland authorities to communicate with the authorized health care provider when necessary.

Parent/Guardian signature: _____ Date:_____