STARFISH FAMILY SERVICES

ALLERGY ACTION PLAN
Please complete entire form

Child's Picture

Child's Name: _____ Date of Birth _____

Center: _____ Teacher/Home Visitor: _____

Parent/Legal Guardian's Name: _____ Phone: _____

Allergy Triggers _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

List accommodations that the child needs to prevent an allergy episode:

_____

Possible warning signs of an allergy episode	*Circle/Check all that apply for allergy episode*
Mouth/ Throat: itching & swelling of lips, tongue, mouth, throat, throat tightness, hoarseness, cough **Skin:** hives, itchy rash, swelling **Gut:** nausea, abdominal cramps, vomiting, diarrhea **Lung*:** shortness of breath, coughing, wheezing **Heart:** pulse is hard to detect, "passing out" *If child has asthma refer to asthma action plan.	____ **1. Call 911** ____ **2. Call Parent** ____ **3. Call Child's Physician** ____ **4. Do CPR if needed** ____ **5. Stay with Child at all times**

Allergy Medication to be given in the classroom – must have Health Care Provider fill out the Medication Authorization Form for school.

List Allergy Medications to be given at Head Start _____ _____

Special Instructions: _____

_____

Health Care Provider _____ **Date:** _____

Health Care Provider _____ **Phone:** _____

Please Print

I agree with the above classroom Action Plan.

_____ _____

Parent/Legal Guardian Signature Date

Head Start Use Only

_____ _____

Family Service Worker Date

_____ _____

Teacher/Home Visitor Date

_____ _____

Site Leader Date

_____ _____

Health Manager or Specialist Signature Date

Note: Parents are responsible for administering medications for home-based children at socializations and other Head Start activities.