MEDICAL PLAN FOR PRESCHOOLERS WITH SEVERE ALLERGIC REACTIONS

Thompson Station Church

Child's Name_____ DOB_____

Parent/Guardian_____ Cell #_____Home#_____

Physician_____Phone#_____

Family member or friend aware of child's condition

Name_____Phone#_____

My child is at risk for a life-threatening allergic reaction: ____ Yes ____ No

My Child has an allergic reaction to:

Bees Latex Food (Please specify which food) _____

Other _____

Please check circumstances which reaction could occur:

_____skin contact _____ingestion (eating allergen) _____inhalation (breathing allergen)

-My child's allergy was identified through allergy testing. ____yes ____ no

-My child had the following symptoms during the reaction: (circle appropriate information)

Red watery eyes Shortness of breath Coughing Swelling Nausea/Vomiting

Runny nose Tightening of throat Hives Dizziness Other _____

If an allergic reaction would occur at church, personnel will administer first aid (remove stinger, apply ice, observe for 15 minutes and record side effects). You will be notified of the incident immediately.

Please indicate which further treatment your health care provider is recommending for your child:

_____Administer medication – Name and dosage_____

_____Call 911 Immediately _____

If Epipen is carried, location_____

Please note that 911 will be called if an Epipen is given or if your child is demonstrating symptoms of a systemic allergic reaction

I hereby give permission for designated church staff to give this medication to my child according to the directions stated above.

I agree to notify the staff in writing at the termination of this request or when any change in the above order is necessary.

Parent signature_____Date_____

Staff Signature_____ Date _____