Allergy Emergency Care Plan

Child's Name:_____ **DOB:** _____

ALLERGIC TO:_____

Asthmatic: ☐ Yes ☐ No

Emergency Contacts:

Parent/Guardian #1: _____

Home: _____ Cell: _____ Work: _____

Parent/Guardian #2: _____

Home: _____ Cell: _____ Work: _____

Other Emergency Contact: _____ Relationship: _____

Home: _____ Cell: _____ Work: _____

Method of Treatment Should a Reaction Occur:

_____

_____

_____

_____

_____

Doctor's Signature: _____ Date: _____

Parent Consent for Management of Allergic Reaction at Cream of the Crop Learning Center

I, the parent or guardian of the above mentioned student, request this emergency action plan to be used to guide allergy care for my child. I agree to:

1. Provide necessary supplies and equipment, including EpiPen and Benadryl if prescribed.
2. Notify COTC of any changes in the student's health status
3. Notify COTC and complete new consent for changes in orders from my child's health care provider.
4. Allow COTC staff interacting direction with my child to be informed about his/her special needs while at school.

Parent/Guardian Signature: _____ Date: _____