Allergy Action Plan

**CHILD’S NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EARLY YEARS SETTING / SCHOOL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HAS THE FOLLOWING ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY TREATMENT**

Name of adrenaline auto injector **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How many adrenaline auto injector been prescribed for use in school?\_\_\_\_\_\_

Name of antihistamine (medicine for allergies).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Refer to label for dosage instructions

Name of inhaler (if prescribed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s date of birth**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NHS Number (If known)

\_ \_ \_ / \_ \_ \_ / \_ \_ \_ \_

**Emergency contact number**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Alternative emergency number**

**if parent / guardian unavailable**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Photo

Mild-moderate allergic reaction:

|  |  |
| --- | --- |
| * Swollen lips, face or eyes
* Itchy/tingling mouth
* Hives or itchy skin
 | * Abdominal pain or vomiting
* Sudden change in behaviour
 |

Action:

* Stay with the child, call for help if necessary
* Give antihistamine according to the child’s allergy treatment plan.
* Locate adrenaline auto-injector (s)
* If wheezy, give Salbutamol (blue inhaler) if prescribed; up to a maximum of 10 puffs may be given per reaction.

**Watch for signs of ANAPHYLAXIS**

(Life-threatening allergic reaction):

Airway: Persistent cough, hoarse voice, difficulty in swallowing, swollen tongue.

Breathing: Difficult or noisy breathing, wheeze or persistent cough.

Consciousness: Persistent dizziness / becoming pale or floppy, suddenly sleepy, collapse, unconscious

If ANY ONE of these signs is present:

1. **Lie child flat.** If breathing is difficult allow to sit. 
2. **Use adrenaline auto injector without delay**
3. **Dial 999 to request an ambulance\*** and say ANAPHYLAXIS (ANA-FIL-AX-IS)

**\*\*\*If in doubt give adrenaline auto injector\*\*\***

**After giving adrenaline auto injector**

1 Stay with child until ambulance arrives; do **NOT** stand child up

2. Commence CPR if there are no signs of life

3. Phone parent/emergency contact

4. If no improvement **after 5 minutes, give a further** **dose of** adrenaline auto injector (if available) in the alternate leg

\*you can dial 999 from any phone, even if there is no credit left on a mobile.

Medical observation in hospital is recommended after anaphylaxis.

**CONSENT**

I consent to the administration of prescribed emergency treatment by members of staff in schools and Early Years settings (EYS).

I will notify school / EYS staff and the school nursing service if there are any changes to my child’s medication and personal details as above.

 I will ensure that the above medication is kept in date and replaced if used.

I consent for my child’s action plan and photo to be displayed within EYS / school

I consent to the use of the school’s generic adrenaline auto injector if available (for those that already have an autoinjector prescribed)

Your name (Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle Parent /Guardian

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anaphylaxis may occur without initial mild signs: **ALWAYS** use adrenaline autoinjector **FIRST** in someone with known food allergy who has **SUDDEN BREATHING DIFFICULTY** (persistent cough, hoarse voice, wheeze)

**Allergy action plan will be reviewed on notification of any changes**