Allergy Health Care Plan 2017-18

Child's name:	
Class:	
Date of Birth:	
Address:	
Date Allergy diagnosed:	
Medication required in school:	

Family Contact Information (3 contacts please in case of emergency)

	Contact 1	Contact 2	Contact 3
Parent/Guardian Name:			
Relationship to child			
Phone number: Home			
Phone number: Work			
Phone number: Mobile			

Describe what an allergy attack looks like for your child and the action to be taken if this occurs. Please provide details of, symptoms, triggers and any required medication.

Advice for Parents/Guardians

Please remember:

- It is your responsibility to tell the school about any changes in your child's allergy or medication.
- It is your responsibility to ensure that your child has their medication with them in school and that it is clearly labelled with their name/class.
- It is your responsibility to ensure that your child's medication has not expired.

I consent that I am happy that the above information be passed onto emergency care staff in the event of an emergency during school hours or during after school activities.

Name of medication in school……

Parent/Guardian Signature…… Date……..

Parent/Guardian (Printed)……