ASKERN MOSS ROAD

Allergy Care Plan

Child's Name	
Date of Birth	
Group / class / form	
Address	
Date completed	

Photo

Family Contact Information

Parent / Carer name	
Phone Numbers	***Please tick the number below that is your preferred contact***
Home	
Mobile	
Work	
Second Emergency Contact	
Name (and relationship to child)	
Phone Numbers	***Please tick the number below that is the preferred contact***
Home	
Mobile	
Work	

GP Details

Name of GP and Practice	
Phone Number	

Clinic / Hospital Contact

Name of Consultant	
Phone Number	

Carol Ann Turner Executive Headteacher
Anne Marie Collins Head of School
Moss Road, Askern, Doncaster, DN6 0NE
Tel: 01302 700287
Email: admin@askernmossroad.co.uk www.askernmossroad.com
@MossRoadAcad

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- Ensure that your child's medication has NOT expired

What is your child allergic to?:

Please tick the symptoms which best describe your child's allergic reaction:

Itchiness of skin	
Skin rash	
Swelling of mouth or throat	
Alterations in heart rate	
Feeling sick	
Vomitting/Diarrhoea	
Abdominal pain	
Cough / Wheeze	
Difficulty in breathing / tightness of chest	
Changes in voice	
Feeling faint / Dizzy	
Looking very pale	
Lips / mouth blue in colour	
Restlessness	
Collapse / Unconscious	
Other:	

What medication has your child been prescribed?

Has your child been admitted to hospital following an allergic reaction? YES / NO

If so, when?

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Has your child had a skin test / blood test to confirm the allergy? YES / NO

What was the result of the test?

Does your child suffer from any other medical condition? YES / NO

If yes please give brief overview:

Describe how the allergy affects your child, including their typical symptoms.

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What are your child's daily care requirements? Include the name of their allergy medication, the dose and how often it is required.

Describe what an attack looks like for your child and the action to be taken.

Who is to be contacted in an emergency? Ensure all contact details are shared

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