

Windmill Creek Academy

An Academic & Creative Preschool



Allergy History and Care Plan

Child's Name:	Date of Birth:
---------------	----------------

My child is allergic to: _____
My child also has asthma: Yes _____ or No _____ (Means higher risk for severe reaction)

This is what happens: (circle all that apply)	
Mouth:	itching and swelling of the lips, tongue and/or mouth
Throat:	itching and/or a sense of tightness in the throat, hoarseness, and a hacking cough
Skin:	Hives, itchy rash, and/or swelling about the face or extremities
Gut:	Nausea, abdominal cramps, vomiting and/or diarrhea
Lung:	Shortness of breath, repetitive coughing, and/or wheezing
Heart:	“Thready” pulse, “passing out”
Other: (Please explain)	_____ _____ _____
This is what you need to do: _____ _____	

The doctor has prescribed an Epi-pen? Yes _____ or No _____

My child has had to have emergency care for an allergic reaction Yes _____ or No _____ (Please explain)

The last reaction happened:

My child's doctor's name is: _____
Phone Number:

Parent Signature: _____ Date: _____