the NANYIMA centre

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Allergy Treatment Plan

Child's Details

Child's name _____ D.O.B. _____ / _____ / _____

Allergy Symptoms

Allergic to: _____

Usual reaction: _____

_____

_____

Reaction is: ❑ **MILD** ❑ **MODERATE** ❑ **SEVERE**

Allergy Treatment

Does your child take any medication to treat the reaction? ❑ Yes ❑ No

If **YES** what medication do they usually take?

Medication: _____ Dosage _____

How often? _____

Has your child been prescribed an **EpiPen/Anapen**? ❑ Yes ❑ No

If **YES**, you will be required to supply us with one, and a copy of your Anaphalaxis Action Plan.

If your child does not require medication for the reaction what is the usual treatment?

_____

_____

_____

Your **emergency** contact number: _____

Name _____

Signature _____ Date _____ / _____ / _____