

Medicines Form 3: Individual protocol for Antihistamine as an initial treatment protocol for mild allergic reaction

CHILD'S NAME	
D.O.B	
Class	

School use attach photo here

Nature of Allergy (Please include type of allergy, expected reaction when the allergy was first noticed, any relevant history):

Contact Information

Name			Relatio pupil	onship to		
Phone numbers	Work	Home	Mobile		Other	

If I am unavailable please contact:

Name			Relatio pupil	onship to		
Phone numbers	Work	Home	Mobile		Other	

<u>GP</u> Name:

Clinic/ Hospital Contact

Name:

Phone No:

Phone No:

Address:

Address:

MEDICATION - Antihistamine

Name of antihistamine & expiry date

.....

• It is the parents responsibility to ensure the Antihistamine has not expired

Dosage & Method: As prescribed on the container.

• It is the schools responsibility to ensure this care plan is reviewed and parents inform the school of any changes in condition or treatment.

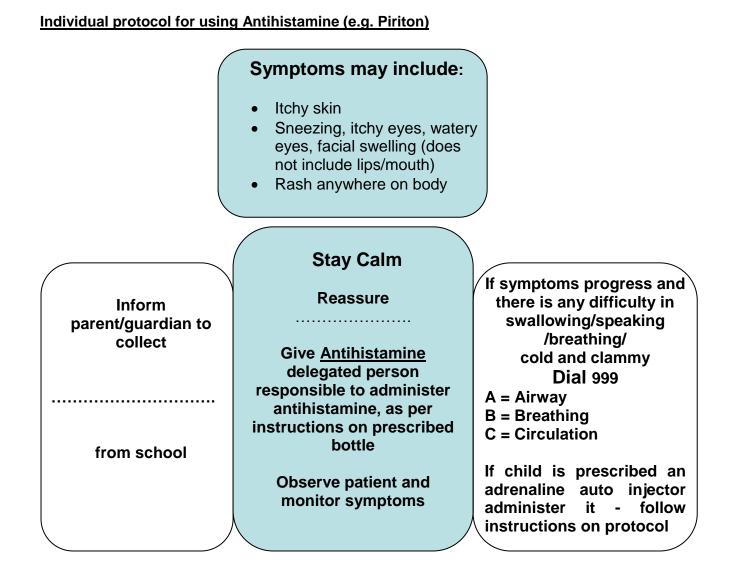
Agreed by: School Representative......Date......Date.....

I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education, and I give my consent to the school to administer anti-histamine as part of my child's treatment for anaphylaxis. I confirm I have administer this medication in the past without adverse effect.

Signed:	Print name
Cignod	1 million 1000000000000000000000000000000000000

Date.....

I am the person with parental responsibility



If symptoms i	progress Dial 999 - [·]	Telephone for a	n ambulance

You need to say:	"I have a child in anaphylactic shock".
	: Brook Infant School, Salterns Road, Maidenbower, Crawley, RH10
7JE.	Telephone number 01293 886521 (then press 3 to come through to
	the office).
Give details:	Pupils name has a severe allergy and what has happened.
DO NOT PUT	THE PHONE DOWN UNTIL YOU ARE SURE ALL THE NECESSARY
	INFORMATION HAS BEEN GIVEN
Someone to wait by	the school gate to direct the ambulance staff straight to the child.