



Dear Parent,

Attached you will find a blank copy of the YWCA plan of care for children with allergies/asthma.

On your child's application you stated they had an allergy or asthma. As requested on your initial application we need a completed plan of care from your physician addressing this allergy.

According to NJ State Regulations 10:122-7.3 we need to have this completed care plan in our office by October 15<sup>th</sup> or your child cannot continue attending the before or afterschool program.

Please feel free to give me a call if you have any questions, I can be reached at 201 881-1726.

*Maire BK*

Maire Brosnan Katavolos  
Director of School Age Programs



## YWCA School Age Program Allergy Action Plan

Please complete the following action plan if your child has any allergy that may require medication or medical intervention. This form must be signed by your child's Doctor.

**Child's Name:** \_\_\_\_\_  
**D.O.B:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **YWCA Site:** \_\_\_\_\_  
**Allergic to:** \_\_\_\_\_  
**Asthmatic** Yes\* No \**Higher risk for severe reaction*

### YWCA Action Principles:

- Give Medication
- Call 911
- Notify Parents/ Supervisor

### WHAT TO DO IF.....

Symptoms	Medications	
	To be determined by physician authorizing treatment	
If a food allergen has been ingested, but no symptoms	Epinephrine	Antihistamine
<b>Mouth</b> - Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine	Antihistamine
<b>Skin</b> - Hives, itchy rash, swelling of the face or extremities	Epinephrine	Antihistamine
<b>Gut Nausea</b> - abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
<b>Throat</b> - Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
<b>Lung</b> - Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
<b>Heart</b> - Weak thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
<b>Other symptoms:</b>	Epinephrine	Antihistamine

### **Dosage**

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg  
*(see reverse side for instructions)*

**Antihistamine:** \_\_\_\_\_  
Medication /dose /route

**Other:** \_\_\_\_\_  
Medication /dose /route

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Dr's Signature is required

I give permission to YWCA staff to follow the above directed action plan in case of allergic reaction. This plan has been reviewed and approved by my child's doctor.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_