MATTHEW GIBNEY CATHOLIC PRIMARY SCHOOL

STUDENT ALLERGY HEALTH CARE PLAN

Child's Name: _____ Class: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Allergen	Treatment/Substitution
_____	_____
_____	_____

Type of allergy transmission/trigger: ☐ Ingestion ☐ Contact ☐ Inhalation

For the following signs of a mild allergic reaction administer: _____

☐ Skin: Hives: Mild Itch

☐ Nose: Itchy, Runny, Sneezing

☐ Stomach: Mild Nausea/Discomfort

☐ Mouth: Itchy

☐ Other:

_____

Other Medication Instructions:

_____

_____

I understand that Matthew Gibney Catholic Primary School requires the most up to date information regarding my child's allergy. I also understand that for the safety of my child, my child's allergy information will be given to all staff.

_____ Date: _____

(Name of Caregiver)

_____ Mobile: _____

(Signature of Caregiver)

Note: Any additional information should be attached.