**Guidelines for the**

**Management of Allergic Reactions in Schools**

|  |  |
| --- | --- |
| **NAME OF CHILD** |  |
|  |  |
| **D.O.B.** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **SCHOOL** | All Hallows Catholic CollegeBrooklands AvenueMacclesfieldCheshireSK11 8LB | **YEAR / FORM** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **CONDITION** |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  | **PHOTO** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**PLEASE SEND THIS FOLDER WITH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IF**

**HE/SHE NEEDS TO ATTEND HOSPITAL**

THE CONTENTS SHOULD THEN BE REVIEWED IN THE LIGHT OF HIS/HER REACTION.

PLEASE INFORM JANET LARTEY, SCHOOL NURSE, BASED AT BROKEN CROSS CHILDRENS CENTRE, PARKETT HEYES ROAD, MACCLESFIELD, SK11 8UD. TEL: 0300 123 4067 OF ANY REACTION. SHE WILL ENSURE THE FAMILY DOCTOR AND HOSPITAL CONSULTANT RECEIVE A WRITTEN REPORT.

**Guidelines for the**

**Management of Allergic Reactions in Schools**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** |  |  | **Date of Birth**: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Class**: |  |  | **Form Teacher**:**(Update Annually)** |  |

|  |  |
| --- | --- |
| **Address**: |  |

|  |
| --- |
|  |

**CONTACT INFORMATION**

**Contacts**:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** |  | **Relationship** |  | **Telephone****Home** |  | **Telephone Work/Mobile** |
|  |  |  |  |  |  |  |
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|  |  |
| --- | --- |
| **General Practitioner**: |  |
|  |  |
| **Hospital Consultant**: |  |
|  |  |
| **Medical Problems**: |  |
|  |  |
| **Medication**: |  |
|  |  |
| **These are kept**: |  |

**Guidelines for the**

**Management of Allergic Reactions in Schools**

**CONSENT FOR TREATMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** |  |  | **Date of Birth**: |  |

|  |  |  |
| --- | --- | --- |
| **M / F** |  |  |

|  |  |
| --- | --- |
| **Address**: |  |

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|  |

[Parents / Guardians]

I / We hereby authorise designated college staff to share personal information re my child and to administer the following medications to my child [details above] if required according to the accompanying guidelines. I/We have parental responsibility for the child.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Signed: |  |  | Name: |  |  | Relationship: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Signed: |  |  | Name: |  |  | Relationship: |  |

EMERGENCY PROCEDURE 1. Give medication as below

 2. Ring 999 for an ambulance

 3. Telephone parents

|  |
| --- |
| Medication and Dose: |

|  |
| --- |
| Medication and Dose: |

|  |
| --- |
|  |

Designated college staff:

|  |
| --- |
| All college staff who have been Epipen trained and All First Aiders. |

|  |
| --- |
|  |

I agree with the above arrangements for the administration of medication in an Emergency by a designated member of college staff who has received appropriate training.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signed: |  |  | Date: |  |

[Principal]

**Guidelines for the**

**Management of Allergic Reactions in Schools**

**EMERGENCY ACTION PLAN**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** |  |  | **Date of Birth**: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Class**: |  |  | **Form Teacher**:**(Update Annually)** |  |

|  |  |
| --- | --- |
| **Address**: |  |

|  |
| --- |
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|  |  |
| --- | --- |
| **Medical Problems**: |  |

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| --- |
|  |

* STAY CALM AND REASSURE STUDENT
* CHECK SYMPTOMS [see Symptom sheet]
* SEND THE STUDENTS MEDICATION IF NOT CARRIED BY STUDENT
* SEND “*CALLING FOR HELP*” SHEET TO COLLEGE OFFICE TO CALL 999
* Remove any causative agent e.g. food from mouth
* POSITION – if student is very pale, or not fully conscious, or feels faint or dizzy, lie student down flat in the recovery position. If the student is conscious but having difficulty breathing, they may be more comfortable in a sitting position.

Medication:

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| --- | --- | --- | --- | --- |
| Signed: |  |  | Date: |  |

**Guidelines for the**

**Management of Allergic Reactions in Schools**

|  |  |
| --- | --- |
| **Medication(s) given:** | **Time(s)** |
| Inhaler |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Antihistamine |  |
|  |  |
|  |  |
|  |  |
|  |  |
| Epipen |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Guidelines for the**

**Management of Allergic Reactions in Schools**

**SYMPTOMS AND SIGNS OF ALLERGIC REACTIONS**

*Common symptoms include:*

* Urticaria = Red, blotchy rash – like nettle rash – “Hives”
* Itching and tingling
* Swelling around the mouth and eyes
* Stomach cramps / vomiting

*More serious features include:*

* Breathing difficulties – e.g. asthma wheezing or due to swelling of the throat
* Changes in voice e.g. hoarseness, due to swelling around voicebox
* Weakness, collapse

**WHEN TO USE AN EPIPEN**

**Give Epipen if showing any of the following symptoms**

* Severe or moderate breathing difficulties – not responding to blue inhaler [e.g. asthma wheezing or due to swelling of the throat]
* Changes in voice e.g. hoarseness
* Weakness, collapse

**Guidelines for the**

**Management of Allergic Reactions in Schools**

**OFFICE STAFF - CALLING FOR HELP**

|  |
| --- |
| **\*\*\* SEVERE ALLERGIC REACTIONS ARE ALWAYS “999” CALLS \*\*\*** |

**RING 999 AND GIVE:**

|  |  |
| --- | --- |
| College Name and Address: | All Hallows Catholic CollegeBrooklands AvenueMacclesfieldCheshireSK11 8LB |

|  |  |
| --- | --- |
| College Telephone Number: | 01625 426138 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Give the students name: |  |  | Date of birth: |  |

State that:

|  |
| --- |
|  |

* Inform the staff looking after the child that the ambulance is on the way.
* Send someone to the college entrance to wait for the Ambulance and direct them promptly to the student.
* Make sure the Ambulance has clear access to the college.
* Inform those on the CONTACT INFORMATION list, usually a parent.
* Record the event in the child’s school record.