International School
HO CHI MINH CITY

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Ho Chi Minh City, Vietnam
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Allergy Action Plan

Name of child: _____Date of Birth: _____
Allergic to: _____
Asthmatic: Yes (Higher risk for severe reaction) No

Daily Medications for allergy:
Name of medication: _____ Dosage: _____

Has s/he ever had a severe allergic reaction or anaphylactic shock?
Yes No
Please tick the symptoms that your child has experienced:

MILD	SEVERE
Itchy Mouth	Swollen lips/tongue/throat
Cough and sneezing	Difficulty breathing/wheezing
Itchy eyes/swollen eyelids	Abdominal cramps
Nausea/vomiting	Heavy sweating
Flush/pallor	Oedema Skin hives/rash

Others: _____

Emergency Medication for allergy:
Name of medication: _____ Dosage: _____

Emergency Treatment
Please indicate:
I wish my child to carry her / his own emergency medication. My child can use his/her medication properly.
My child should not use medication by him/herself so I wish my child's medication to be stored in the school clinic. The school clinic staff can administer the above medication if needed.

ISHCMC has a policy for Allergies and Anaphylaxis. Adrenaline is kept in the school clinic and will be given by intra muscular injection to any student with clinical symptoms of Anaphylaxis.

Date: _____ Parent/Guardian signature: _____

Name of Parent/Guardian printed: _____

If you have any further questions, please contact our school clinic during school hours or phone 8989 100 ext. 105.