St Albans Girls' School

Learning for Life in a Community where All can Excel

STUDENT ALLERGY INDIVIDUAL HEALTHCARE PLAN (IHP)

(to be completed by Parent/Carer. This form is also available on our website)

Student's name	
Form	
Date of birth	
What are your daughter/son's allergies? Please list all known allergens.	

Parent/Carer Contact Information

Name	
Relationship to student	
Emergency contact number	

MEDICATION : What medication(s) has your daughter/son been prescribed. Please list dose, method of administration, when to be taken, side effects, contra indications, administered by/self-administered with/without supervision *(only to be completed if medication is required to be taken in school)*

ADDITIONAL SUPPORT: Describe any additional support *(other than medication)* your daughter/son requires (e.g. facilities, equipment or devices, environmental issues, physical adaptations etc)

DAILY CARE : Please specify below any daily care requirements, e.g. before sport, at lunchtime, if applicable.

TRIGGERS and SIGNS: What are the triggers, signs & symptoms that an allergic reaction may be imminent?

How is an allergic reaction identified & what treatment should be given?

Action to take in an emergency

G.P. Contact

Name	
Address and Telephone Number	

Can the named GP be contacted for information where required (delete as applicable) YES/NO

OTHER INFORMATION

When was your daughter/son diagnosed with a severe allergy?			
Is your daughter/son's allergy (*please tick)*	Mild	Moderate	Severe
Does your daughter/son have disturbed sleep due to his/her allergy? (please tick)	Rarely	Occasionally	Frequently
How many times, if any, has your daughter/son attended hospital as a result of an allergic reaction in the past year?	Not attended	Once or more	State how many times
Who monitors your daughter/son's allergy? *(if under a hospital, please give name of hospital and consultant)*			
How often is your daughter/son seen by the hospital/GP/nurse? *(please tick)*	Only when she/he has had an allergic reaaction	On a 3-6 month basis (or more frequent)	Annual check by GP

SIGNATURE _____**Date**_____
(Parent/Carer)

NAME (print) _____

FOR OFFICE USE ONLY

Input:_____ Checked: _____

Initial:_____ Date:_____

APPENDIX 1 PARENTAL CONSENT FORM

FOR USE OF EMERGENCY ADRENALINE AUTO-INJECTOR AT SCHOOL

For students who have been diagnosed with an allergy and need to carry an Adrenaline Auto Injector (AAI)

Student's name	
Form	
Date of birth	

1. I can confirm that my daughter/son has been diagnosed with a severe allergy.
2. My daughter/son has a working, in-date Adrenaline Auto Injector (AAI), clearly labelled with their name, which they will bring with them to school every day.
3. In the event of my daughter/son displaying symptoms of an allergic reaction, and if their AAI is not available or is unusable, I consent for my daughter/son to receive adrenaline from an emergency AAI held by the school for such emergencies.

Parent/Carer Signature: _____ Date:_____

Name (print): _____

Parent/Carer Contact Information

Name	
Address	
Relationship to student	
Emergency contact number	