Individual Child Care Program Plan
Child with Severe Allergies/ Allergies

FORM A-500
©Revised 3/18

Place Child's Picture Here

Child's Name: ________________________ Date of Birth: __/__/__

Allergy to: ________________________

Any other known triggers: ________________________

Signs of an allergic reaction include: (*May differ from each exposure and severity of symptoms can quickly change.*)

Systems:	Symptoms:
• Mouth	itching and swelling of the lips, tongue, or mouth
• Throat*	itching and/or a sense of tightness in the throat, hoarseness and hacking cough
• Skin	hives, itchy rash, and/or swelling about the face or extremities
• Gut	nausea, abdominal cramps, vomiting, and/or diarrhea
• Lung*	shortness of breath, repetitive coughing, and/or wheezing
• Heart*	"weak" pulse, "passing-out"

*** All above symptoms can potentially progress to a life-threatening situation!**

TO BE COMPLETED BY HEALTH CARE PROVIDER

If reaction is suspected give IMMEDIATELY:

Treatment prescription #1: ________________ Dosage: ________

For the described symptoms: ________________________

Treatment prescription #2: ________________ Dosage: ________

For the described symptoms: ________________________

Precautions and/or possible adverse reactions: ________________________

Contact emergency medical services whenever epinephrine is used.
(A single dose of epinephrine wears off in 15-20 minutes)

Other pertinent information: ________________________

Please note: In the case of a severe allergy to bee stings, the provider will attempt to quickly remove the stinger by scraping with a fingernail or other object.

Physician's signature: ________________________ Date: __/__/__

EMERGENCY PHONE NUMBERS

Parent/Guardian #1: ________________________
Name Home # Work # Other #

Parent/Guardian #2: ________________________
Name Home # Work # Other #

(See emergency contact information for alternate if parents are unavailable)

Primary health care provider's name: ________________ emergency phone: ________

Specialist's name (if any): ________________ emergency phone: ________

I give my permission for the provider to follow this plan of care prescribed by the physician. I also give my permission to call the health care provider(s) listed above for any additional medical information about my child. I understand that a photo of my child including my child's name and specific allergies and treatment will be posted at the program.

Parent/Guardian's signature: ________________________ Date: __/__/__

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TO BE COMPLETED BY CHILD CARE PROVIDER

Techniques to avoid exposure: ______________________________

Who will take charge of the situation if a reaction occurs? ______________________________

Where will the medications needed for a reaction be kept? (Recommend in the same room or location as the child) ______________________________

Where in the program will the child receive care when a reaction occurs? ______________________________

What will the staff do if the child is?
...On the playground? ______________________________
...On a field trip? ______________________________

Where will the medications be kept while on a field trip: ______________________________

Who will call the Emergency Medical System (911)? ______________________________

Who will call the parents/guardian? ______________________________

Who will go with the child to the hospital and stay until the parents can assume responsibility? ______________________________

Who will care for the other children if the caregiver must take the allergic child away from the group? ______________________________

Is the allergy **with** the child's picture prominently posted in the kitchen **and** the eating area?
Yes / No

TRAINED CHILD CARE PROVIDERS: (Must be reviewed with any changes in the plan, if needed, attach more signatures to this form)

1. ______________________________ Date: ____/____/____

2. ______________________________ Date: ____/____/____

3. ______________________________ Date: ____/____/____

4. ______________________________ Date: ____/____/____

5. ______________________________ Date: ____/____/____

Plan of care written in collaboration with:
Director: ______________________________ Date: ____/____/____

Projected date of plan re-evaluation: (Reviewed and signed by licensed physician, psychiatrist, psychologist, or consulting psychologist at least annually) Date: ____/____/____