Plan of Care for **Allergies**

**Child’s Name: Date of Birth: Age:**

**Physician child sees for Allergies:**

Name (please print) Phone Number

**Medications your child uses for prevention of his/her allergy:**

(\* Please list medications for Emergency treatment of an allergic reaction on next page.) Name of Medication(s) Dosage Time(s) of day given

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Would medication(s) need to be given during normal program hours? ………….YES/NO Would medication(s) need to be given during non-school days? ………………...YES/NO If **yes** to either question, a permission slip, completed by your child’s doctor is required.

**Identify the things that start an allergy episode** (check any that apply to your child)

 Animals

 Bee/insect sting

 Chalk dust Change in temperature

 Dust mites

 Exercise

 Latex

 Molds

 Pollens

 Respiratory infections Smoke Strong odors

 Food

 Other

**Control of the Child Care Environment**

List any environmental control measures, premedications &/or dietary restrictions that your child needs to avoid an allergy episode.

**Outside activity & field trips** (List the medications that must accompany your child on these activities)

Name Dosage When to use

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**YOUR child’s symptoms of an allergic reaction:** (Please circle those that apply)

**Mouth/throat:** itching & swelling of lips, tongue, mouth, throat; cough; hoarseness;

difficulty swallowing

**Skin:** hives; itchy rash; swelling; flushed or unusually pale skin color **Lung:** difficulty breathing; shortness of breath; coughing; wheezing **Gut:** abdominal cramps; nausea; vomiting; diarrhea

**Heart:** fainting; pulse is hard to detect

**Others:**

**The usual procedure at for a child having an allergy episode:**

1. If the above symptoms occur, administer the medication(s) listed below.

2. Have the child lie down.

3. Do not give the child anything by mouth, except emergency medications.

4. Monitor ABC’s.

5. If **severe allergic symptoms** develop (hives all over the body; severe swelling of the eyes, skin, tongue, or throat; wheezing; nausea; vomiting; diarrhea; fainting) call for **Emergency Medical Services**.

6. Notify parent/guardian of any allergic symptoms, whether mild or severe.

7. Any special instructions from parent or physician:

**EMERGENCY allergy medication(s):**

Name Amount When to use

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Parents provided an **Epi-pen**: YES NO

If you have provided an **Epi-pen**, a permission slip completed by your doctor is required.

**Review of above information & signatures for this year:**

Parent/Guardian Signature Provider Signature

Date Date