

# 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:

- Mouth
- Throat\*
  
- Skin
- Gut
- Lung\*
- Heart\*

Symptoms:

itching and swelling of the lips, tongue, or mouth  
itching and/or a sense of tightness in the throat, hoarseness and  
hacking cough  
hives, itchy rash, and/or swelling about the face or extremities  
nausea, abdominal cramps, vomiting, and/or diarrhea  
shortness of breath, repetitive coughing, and/or wheezing  
"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: \_\_\_/\_\_\_/\_\_\_ - Over -

**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: \_\_\_/\_\_\_/\_\_\_