ALLERGY HEALTH CARE PLAN

Child's Name _____ DOB _____

Parent/Guardian Name _____ Phone _____

Physician Name _____ Phone _____

ALLERGEN	TREATMENT/SUBSTITUTION
_____	_____
_____	_____
_____	_____
_____	_____

Type of allergy transmission/trigger: ☐ Ingestion ☐Contact ☐Inhalation

NOTE: Do Not Depend on Antihistamines or Inhalers to treat a SEVERE reaction. USE EPINEPHRINE

Extreme Reactive to the Following Foods _____.

- ☐ If checked, give epinephrine for ANY symptoms if the allergens was likely eaten.
- ☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

For the following signs of a *mild* allergic reaction administer: _____

_____

☐ **Skin:** Hives: Mild Itch

☐ **NOSE:** Itchy, Runny, Sneezing

☐ **Stomach:** Mild Nausea/Discomfort

☐ **Mouth:** Itchy

☐ **Other:** _____

For any of the following signs of SEVER allergic reaction or a combination of symptoms from different body areas. Give EPINEPHRENE and CALL 911. If prescribed and directed, give other medications (antihistamine/inhaler). Lay person flat. If breathing is difficult or vomiting, place on side or sit up.

☐ **Mouth:** Significant Swelling of Tongue and/or Lips

☐ **Heart:** Pale, blue, faint, weak pulse, dizzy

☐ **Throat:** Tight, hoarse, trouble breathing/swallowing

☐ **Lungs:** Short Breath

☐ **Skin:** Many hive over body, widespread redness

☐ **Stomach:** Repetitive vomiting, severe diarrhea

☐ **Other:** Feeling something bad is about to happen; anxiety, confusion

Other Medication Instruction: _____

_____

_____

PRESCRIBED MEDICATION/DOSAGE

Epinephrine (Brand and dose) : _____

Antihistamine: (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Potential Side Effects of Medication: _____

_____

Potential Consequences to Child if Treatment is Not Administered: _____

_____

STAFF TRAINING

Staff may be trained by: _____

The following staff have been trained on the child's medical condition:

_____ _____

_____ _____

_____ _____

PARENT/GAURDIAN ACKNOWLEDGEMENT STATEMENT

To ensure the safety of your child we cannot delete an allergy which has previously been documented unless we have a signed note from the child's physician stating that the child is no longer allergic to this item(s) and may now have the specific food(s); or be exposed to the item(s); nor can we add an item (s) or change a medication without a signed note from the child's physician.

I understand that Kiest Park Christian Preschool requires the most up to date information regarding my child's allergy. I also understand that the safety of my child, my child's photograph and allergy information will be posted in the classrooms and kitchen.

_____ _____

Physician Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Director/Principle Signature Date

This plan must be updated annually or whenever there is any change in treatment or the child's condition changes.

For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the Medication Authorization.