Individual Child Care Program Plan Child with Severe Allergies, Allergies

Child with	Severe Allergies, Allergies	Place
	Date of Birth:/	Child's Picture Here
Signs of an allergic read	ction include: (May differ from each exposure and seve	erity of symptoms can
Systems: Mouth Throat* Skin Gut Lung* Heart* All above symptoms can p	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" otentially progress to a life-threatening situation!	
If reaction is suspected give	1: Dosage:	

If reaction is suspected give IMMEDIATELY: Treatment prescription #1: For the described symptoms: Treatment prescription #2: For the described symptoms:		Dosage: _		
Precautions and/or possible adverse reactions: Contact emergency medical services when (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 quickly remove the stinger by scraping with a fing	ever epinep	hrine is use	d.	
Physician's signature:	=	-	Date:/	
EMERGENCY PHO	NE NUMBERS			
Parent/Guardian #1:				
Name Parent/Guardian #2:		Work #	Other #	
	Home #			
Primary health care provider's name:		emergency phone:		
Specialist's name (if any):	ε	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 -

FORM A-500

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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? (Recommo		
Where in the program will the child receive care when a reaction occur	s?	
What will the staff do if the child is?On the playground?		
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 ca		
Who will care for the other children if the caregiver must take the all group?		
Is the allergy with the child's picture prominently posted in the kitcher Yes / No	n and the eating area?	
RAINED CHILD CARE PROVIDERS: (Must be reviewed with any changes in attach more signatures to this form)	the plan, if needed, Date://	
·	Date://	
	Date:/	
•	Date://	
•	Date://	
lan of care written in collaboration with: irector:	_ Date://	
rojected date of plan re-evaluation: (Reviewed and signed by licensed hysician, psychiatrist, psychologist, or consulting psychologist at least a	Date:// annually)	