Written Care Plan for a Child with Allergies

Child Information

Last Name	First Name	Birthdate (mm/dd/yyyy)

Parent Or Guardian

Last Name	First Name	Phone No.

Physician's Name: _____ Physician's Number: _____

1. Please indicate items your child has an allergy to:

☐ Peanut / Peanut Products ☐ Milk ☐ Nuts ☐ Gluten

☐ Soy Products ☐ Eggs ☐ Fish / Shellfish ☐ Bee Stings

☐ Other (please indicate):

2. What steps need to be taken to avoid an allergic reaction?

_____

_____

3. What are the specific signs and symptoms if your child is having an allergic reaction?

_____

_____

4. What treatment or medication does your child receive in the event of an allergic reaction? (include medication name, dose, method of administration, and when it should be administered):

_____

_____

5. What are the procedures for responding if your child has an allergic reaction? Note if your child is able to give themselves medication.

_____

_____

Signature of Parent / Guardian _____ Date _____

******If your child's allergy plan includes medication for the treatment of allergy symptoms, a completed Medication Permission and Administration form must accompany this allergy plan.***