

# INDIVIDUALIZED CHILD CARE PROGRAM PLAN

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## Allergies

Student's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**DESCRIPTION OF THE ALLERGY:** \_\_\_\_\_

**SPECIFIC TRIGGERS:** \_\_\_\_\_

**AVOIDANCE TECHNIQUES:** \_\_\_\_\_

### **SYMPTOMS OF ALLERGIC REACTION INCLUDE:**

Mouth	Itching and swelling of the lips, tongue, or mouth
Throat	Itching and/or a sense of tightness, hoarseness, trouble inhaling or talking
Skin	Hives, itchy rash, and/or swelling
Gut	Nausea, abdominal cramps, vomiting, and/or diarrhea
Lung	Shortness of breath, repetitive coughing, and/or wheezing
Heart	Weak pulse, passing out

The severity of symptoms can quickly change. All the above symptoms can potentially progress to a life threatening situation.

### **PROCEDURES FOR RESPONDING TO AN ALLERGIC REACTION:**

\_\_\_\_\_

**MEDICATION AND DOSAGES:** \_\_\_\_\_

\_\_\_\_\_

### **DOCTOR CONTACT INFORMATION:**

Primary health care provider \_\_\_\_\_ phone \_\_\_\_\_

Parent/guardian #1 \_\_\_\_\_ home/cell phone \_\_\_\_\_

Parent/guardian #2 \_\_\_\_\_ home/cell phone \_\_\_\_\_

DO NOT HESITATE TO ADMINISTER MEDICATION OR HAVE THE CHILD TRANSPORTED TO A MEDICAL FACILITY EVEN IF PARENTS CANNOT BE REACHED.

Parent/guardian signature: \_\_\_\_\_ Date \_\_\_\_\_

Health care provider's signature \_\_\_\_\_ Date \_\_\_\_\_

Print health care provider's name: \_\_\_\_\_