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 _____