Special Needs Care Plan for a Child with Environmental or Seasonal Allergies

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Class: \_\_\_\_\_\_\_\_\_\_

This individual care plan is written for a child diagnosed with environmental or seasonal allergies that are not life threatening and do not require emergency medication. This information will give staff a better understanding of the child’s triggers, signs, and symptoms.

Diagnosis: [ ]  Environmental allergies [ ]  Seasonal allergies

* Does the child take medication at home? [ ]  YES [ ]  NO
* Will the child have medication to be administered at school? [ ]  YES [ ]  NO
	+ If yes, the health care provider will complete the *Medication Consent Form.*

|  |
| --- |
| KNOWN TRIGGERS (circle all that apply) |
| Smoke | Mold | Dust | Weather changes | Perfumes |
| Pollen | Animals | Grass | Cleaning products |  |
| Other: |

|  |
| --- |
| SIGNS AND SYMPTOMS (circle all that apply) |
| Runny nose | Coughing | Sneezing | Congestion |
| Itchy, watery eyes | Puffy eyes | Post-nasal drip |  |
| Other: |
| Do you consider these signs/symptoms to be mild or severe? |
| Frequency of symptoms: [ ]  Daily [ ]  Intermittent [ ]  Infrequent |
| Strategies to reduce the risk of exposure to the child’s allergens include: |
| Do the staff need any additional training to care for this child? [ ]  YES [ ]  NOIf yes, please specify: |
| STAFF TRAINED TO PROVIDE CARE  |
| Staff: | Credentials: |
|  |  |
|  |  |
|  |  |
|  |  |
| General Plan of Action if the Child is Experiencing Allergy Symptoms  |
| 1. Remove any known triggers
 |
| 1. Provide medication as instructed on the *Medication Consent Form* (if applicable)
 |
| 1. Notify parent if the child’s symptoms are worsening and becoming more severe
 |
| 1. Call 911 if the child is having difficulty breathing or shows signs and symptoms of anaphylaxis
 |
| Other specific instructions: |

***Program information and signatures on reverse***

This care plan was developed in close collaboration with the child’s parent/guardian and health care provider. The program understands its responsibility to follow the plan and ensure that staff are informed and trained according to the plan requirements.

|  |
| --- |
| Program Name |
| Program License # | Program Phone # |
| Child Care Provider’s Name: |
| Child Care Provider’s Signature/Date: |
| Parent/Guardian Name and Phone #: |
| Parent/Guardian Signature/Date: |
| Health Care Provider Name: |
| Health Care Provider Address and Phone #: |
| Health Care Provider Signature/Date: |
| ADDITIONAL NOTES: |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |