A logo with colorful leaves

AI-generated content may be incorrect.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.*

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| --- | --- | --- | --- | --- |
| 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  NO  If yes, please specify: | | | |
| STAFF TRAINED TO PROVIDE CARE | | | |
| Staff: | | Credentials: | |
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| 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.

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| --- | --- |
| 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: | |
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