



## ALLERGY CARE PLAN FOR A CHILD WITH DIAGNOSED FOOD ALLERGIES

|                                                  |                               |
|--------------------------------------------------|-------------------------------|
| <b>Child's Name:</b>                             | <b>Child's Date of Birth:</b> |
| <b>Name of the Child's Health Care Provider:</b> |                               |
| <b>Food Allergies:</b>                           |                               |

**Steps to be taken in the event of a suspected or confirmed allergic reaction:**

**Signature of Authorized Program Representative:** I understand that it is my responsibility to follow the above plan. This plan was developed in close collaboration with the child's parent and the child's health care provider. I understand that staff who provide all treatments and administer medication to the child listed in the allergy care plan must have received Medication Administration Training; is CPR and first aid certified; or has a license that exempts them from training; and have received any additional training needed.

|                                                             |                          |                                   |
|-------------------------------------------------------------|--------------------------|-----------------------------------|
| <b>Provider/Facility Name:</b>                              | <b>Facility address:</b> | <b>Facility Telephone Number:</b> |
| <b>Authorized child care provider's name (please print)</b> |                          | <b>Date:</b>                      |
| <b>Authorized child care provider's signature:</b>          |                          |                                   |

|                                           |              |
|-------------------------------------------|--------------|
| <b>Signature of Parent or Guardian:</b>   | <b>Date:</b> |
| <b>Signature of Health Care Provider:</b> | <b>Date:</b> |