ALLERGY CARE PLAN

CENTER _____

Child's Name _____ **DOB** _____

ALLERGY TO: _____

Asthmatic Yes* ☐ No ☐

*Higher risk for severe reaction

Symptoms:

If a food allergen has been ingested, but no symptoms

Mouth	Itching, tingling, or swelling of lips, tongue, or mouth
Skin	Hives, itchy rash, swelling of the face or extremities
Gut	Nausea, abdominal cramps, vomiting, diarrhea
Throat+	Tightening of throat, hoarseness, hacking cough
Lung+	Shortness of breath, repetitive coughing, wheezing
Heart+	Thready pulse, low blood pressure, fainting, pale, blueness
Other +	

Note: The severity of symptoms can quickly change.

+Potentially life threatening

STEP 1 _____

_____

STEP 2 _____

_____

STEP 3 **In the event that a parent/guardian cannot be reached, the emergency plan will be instituted**

CALL 911. Do Not Hesitate.

Dr. _____ **At** _____

Call Emergency contacts:

Name/Relationship Phone Number(s)

_____

_____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Site Director Signature: _____ Date: _____

Program Director Signature: _____ Date: _____

Executive Director Signature: _____ Date: _____

All TLC staff are to review, sign and date on the back of this form regardless of work schedule.

TLC Staff Signature: _____ Date: _____

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