HEAD START

Tri-County Community Council, Inc.
2499 Cypress St. Westville, Fl 32464
(850) 548-9900 FAX (850) 548-5644

ALLERGY HEALTH CARE PLAN

Child's Name:_____
D.O.B.:____/____/____
Parent/Guardian Name:_____
Phone:_____
Parent/Guardian Name:_____
Phone:_____
Emergency Contact:_____
Phone:_____
Allergies:_____
Insurance:_____

Health Care Provider:_____
Phone:_____
Teacher/Family Advocate:_____
Site/Loc:_____

Allergy(s):
List what your child is allergic to:

_____
_____
_____

Describe how your child responds to the allergen:

_____
_____
_____

Child involvement:
Is your child aware of the allergy and how to avoid exposure to the allergen?

_____
_____
_____

Response:

1. Observe and assist the child
2. Give medication if prescribed (see medication directions)
3. Contact parent/guardian if:_____
4. Call 911 if:_____

What are your directives to classroom staff if an allergic reaction occurs?

_____
_____

Current Medications			
Mediation(s) Name	Dosage Amount	Prescribed times to give	Dosage Frequency (How far apart to be

given)
1.
2.
3.

ALLERGY CARE PLAN continued

Child's Name:_____

Will medication be at school? ☐ Yes ☐ No

If yes, Medication Authorization Form required prior to medication administration. Received: ☐ Yes ☐ No

Food Allergies:

If this is a food allergy, please list menu change requests and include Physicians documentation.

_____

_____

Field Trips:

Is medication need for field trips? ☐ Yes ☐ No

If yes, designated classroom staff will follow the medication Administration procedures for administering and monitoring medication while on field trips and fill out appropriate forms per the Health Services Supervisor.

Parent Directives:

Equipment and Supplies provided by parent/guardian	o Medication o Epi-pen o Other:_____	Disaster Supplies: o Medication for 3 days o Out-of-town contacts

Out-of-Town Contacts:

Name:_____ Phone:_____

Name:_____ Phone:_____

Training Needs:

Is specialized training necessary for classroom staff? ☐ Yes ☐ No _____

If yes, the Health Services Coordinator will offer training. Will parent/guardian be available to assist with that training in order to individualize and meet the child's health care needs? ☐ Yes ☐ No

_____ _____

Parent/Guardian Signature Date Parent/Guardian Signature
Date

_____ _____

Staff Signature Date RN Signature Date