JACK & JiLL
EARLY CHILDHOOD LEARNING

SEVERE ALLERGY CARE PLAN

Child's Name ____

Date of Birth (mm/dd/yyyy) ________________________

Allergy To ______________________________________

Specific Triggers ☐ eating ☐ breathing (inhale) ☐ touching

☐ insect bite ☐ other:______________________

PLACE CHILD'S PICTURE HERE

SIGNS OF AN ALLERGIC REACTION

Systems	Symptoms
Mouth	itching and swelling of the lips, tongue, or mouth
Throat*	itching and/or a sense of tightness in the throat, hoarseness and hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Gut	nausea, abdominal cramps, vomiting, and/or diarrhea
Lung*	shortness of breath, repetitive coughing, and/or wheezing
Heart*	weak pulse, passing out

INSTRUCTIONS FROM A HEALTH CARE PROVIDER

Medication Instructions

1. ____________________________ for described symptoms __________________________________ Dosage: ____________

2. ____________________________ for described symptoms __________________________________ Dosage: ____________

3. ____________________________ for described symptoms __________________________________ Dosage: ____________

Contact emergency medical services whenever epinephrine is used. (A single dose of epinephrine wears off in 15–20 minutes)

PLEASE NOTE: In the case of a severe allergy to bee stings, the provider will attempt to quickly remove the stinger by scraping with a fingernail or other object.

PHYSICIAN'S SIGNATURE REQUIRED

Primary health care provider's name: ______________________________ emergency phone: ________________________

Specialist's Name (if any): ____________________________________ emergency phone: ________________________

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

X ___________________________________ **Signature of Physician** ________________ **Date**

EMERGENCY PHONE NUMBERS

Parent/Guardian 1: ________________ Name ________________ Primary Phone # ____________ Work # ____________ Other #

Parent/Guardian 2: ________________ Name ________________ Primary Phone # ____________ Work # ____________ Other #

(See emergency contact information for alternate if parents are unavailable)

I give permission to Jack & Jill Early Childhood Learning to follow the plan of care prescribed by the physician. I also give my permission to share my child's information with emergency responders. I understand that a photo of my child including my child's name and specific allergies and treatment will be posted and visible to others at the program.

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

X ___________________________________ **Signature of Parent/Guardian** ________________ **Date**

SEVERE ALLERGY CARE PLAN (CONTINUED)

TO BE COMPLETED BY CHILD CARE PROVIDER

Techniques to avoid exposure: ______________________________

Who will take charge of the situation if a reaction occurs? ______________________________

Where will the medications needed for a reaction be kept? ______________________________
(Recommend in the same room or location as the child)

Where in the program will the child receive care when a reaction occurs? ______________________________

____

What will the staff do if the child is...

on the playground? ______________________________

on a field trip? ______________________________

Where will the medications be kept while on a field trip? ______________________________

Who will call 911? ______________________________

Who will call the parents/guardian(s)? ______________________________

Who will go with the child to the hospital and stay until the parents can assume responsibility? ______________________________

____

Who will care for the other children if the caregiver must take the allergic child away from the group? ______________________________

____

Is the allergy with the child's picture available in the kitchen AND the eating area? ☐ Yes ☐ No

TRAINED CHILD CARE PROVIDERS (Name and date trained)

Must be reviewed with any changes to the plan. If needed, attach more signatures to form.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

Date current ICCPP was created: **Date:** ____________

Plan of care written in collaboration with: ______________________________

Projected date of plan re-evaluation: (Done at least annually) **Date:** ____________

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