

All Stars Montessori Care Plan for Child with Severe Allergies

Place child's
picture here.

Child's name: _____ Date of Birth: _____

ALLERGY: _____

Asthmatic: Yes No *Higher risk for sever reaction.

◆ STEP 1: TREATMENT ◆

Physician: Please indicate which treatment is to be given for indicated symptoms.

For these symptoms:

- If a food allergen has been ingested, but *no symptoms*:
- Mouth itching, tingling, or swelling of lips, tongue, mouth
- Skin hives, itchy rash, swelling of the face or extremities
- Gut nausea, abdominal cramps, vomiting, diarrhea
- Throat † tightening of throat, hoarseness, hacking cough
- Heart † thready pulse, low blood pressure, fainting, pale, blueness
- Other _____
- If reaction is progressing (several of the above areas affected), give † *These symptoms are potentially life threatening.*

Give medication indicated:

(dosage noted below)

- | | |
|----------------------------------|---|
| <input type="checkbox"/> Epi-Pen | <input type="checkbox"/> Benadryl/Antihistamine |
| <input type="checkbox"/> Epi-Pen | <input type="checkbox"/> Benadryl/Antihistamine |
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| <input type="checkbox"/> Epi-Pen | <input type="checkbox"/> Benadryl/Antihistamine |

DOSAGE:

Epi-Pen: inject intramuscularly (circle one): EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

Benadryl/Antihistamine: give _____
(medication/dose/route)

Other: give _____
(medication/dose/route)

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (if Epi-Pen is administered).
2. Call Dr. _____ at _____ .
3. Call parents or emergency contacts:
Mom: _____ at _____
Dad: _____ at _____
_____ at _____
_____ at _____

I give my permission for the provider to follow this plan of care prescribed by the physician. I also give my permission to call the health care provider(s) listed above for any additional medical information about my child. I understand that a photo of my child including my child's name and specific allergies and treatment will be posted at the program.

Physician's signature _____ Date: _____

Parent's signature _____ Date: _____