Allergy Care Plan

Child's Name _____ Birth Date _____

What is the child allergic to?

How is the allergic reaction the child gets?

What special needs does the child have associated with this allergy?

What will Head Start Staff need to be aware of?

What medication does child take, if any, for this allergy and will they need to be given at Head Start?

Parents Signature _____ Date _____

Health Care Professional _____ Date _____

Head Start Supervisor _____ Date _____

The Following Individuals Were Present for Allergy Care Plan Meeting

Date _____

Name	**Title**