**Excellence Learning Pod**
Renton, WA · (206) 251-4540 · charrita@excellencelearningpod.org

# Allergy & Individual Care Plan

For children with allergies or special health needs. Complete with your health care provider.

CHILD'S FULL NAME

TODAY'S DATE

## Contact Information

PARENT / GUARDIAN NAME

TELEPHONE

PARENT / GUARDIAN NAME

TELEPHONE

PRIMARY HEALTH CARE PROVIDER

TELEPHONE

SPECIALIST (IF APPLICABLE)

TELEPHONE

## Child's Special Needs

DIAGNOSIS, IF KNOWN

KNOWN SYMPTOMS AND TRIGGERS

ACTIVITY, BEHAVIORAL, OR ENVIRONMENTAL MODIFICATIONS NEEDED

ALLERGIES (OTHER THAN FOOD ALLERGY)

For food allergies or special dietary needs due to a health condition, written instructions from the child's health care provider are required (see the Food Allergy page).

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## Medications

A Medication Authorization Form must be completed for each medication.

MEDICATION TO BE GIVEN AT SCHEDULED TIMES, AND HOW IT IS TO BE GIVEN

MEDICATION TO BE GIVEN DURING AN EMERGENCY, AND HOW IT IS TO BE GIVEN

SYMPTOMS THAT WOULD TRIGGER EMERGENCY MEDICATION

## Emergency Response Plan

STEPS AND PROCEDURES STAFF SHOULD PERFORM DURING AN EMERGENCY RELATED TO YOUR CHILD'S SPECIAL NEED

## Suggested Training for Staff

SUGGESTED SPECIAL SKILLS TRAINING / EDUCATION FOR PROGRAM STAFF

## Supporting Documentation

Please attach supporting documentation to this Individual Care Plan, including any IEP, IHP, 504 plan, or IFSP. Per WAC 110-300-0300 / 110-301-0300, supporting documentation must be provided by the child's licensed or certified physician or PA, mental health professional, educational professional, qualified social worker, or RN/ARNP.

## Signatures

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PARENT / GUARDIAN SIGNATURE

DATE

EARLY LEARNING / SCHOOL-AGE PROVIDER SIGNATURE

DATE

HEALTH CARE PROVIDER (RECOMMENDED) SIGNATURE

DATE

## Food Allergy & Special Dietary Requirements

This section must be completed and signed by the child's health care provider and parent/guardian.

CHILD'S FULL NAME

TODAY'S DATE

| FOOD THE CHILD MUST NOT CONSUME | APPROPRIATE SUBSTITUTE FOOD(S) |
|---|---|
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| | |

DESCRIBE ALLERGIC REACTIONS AND SYMPTOMS ASSOCIATED WITH THIS CHILD'S ALLERGIES

TREATMENT PLAN FOR STAFF TO FOLLOW (MEDICATION NAMES, DOSAGE, HOW TO ADMINISTER)

OTHER SPECIAL DIETARY REQUIREMENTS DUE TO A HEALTH CONDITION

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HEALTH CARE PROVIDER SIGNATURE

DATE

PARENT / GUARDIAN SIGNATURE

DATE