Individual Health Care Plan (Allergy/Asthma)

Emergency Information

Child's Name ____________________________

Primary Care Provider: ______________________ Contact # ____________________________

Allergist (if applicable) ______________________ Contact # ____________________________

Best # to inform Parents of Allergic Reaction ____

Secondary Emergency Contact ____

Allergy Information

Known Allergy/Condition ____
Symptoms ____

Treatment Plan: ____
____
____

Please describe past allergic reactions, including triggers & warning signs:
____
____
____

Please describe child's emotional response and suggestions for support:
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____
____

Attached

- ☐ Pediatrician Documentation of Allergy/Condition
- ☐ Medication Consent Form (signed by parent/guardian and pediatrician/allergist for OTC)
- ☐ Prescription for medication if applicable

Parent(s) Signature ____________________________________ Date: ____________