



Sunshine School

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SPECIAL CARE PLAN FOR A CHILD WITH ALLERGIES

Child's Name: _____ Date of Birth: _____

Parent(s) or Guardian(s) Name: _____

Emergency Phone Numbers: Mother _____ Father _____

Primary Health Provider Name: _____ Emergency Phone: _____

Specialist's Name (if any): _____ Emergency Phone: _____

Description of Allergy: _____

Describe what signs/or symptoms look like: _____

Describe known triggers: _____

Describe treatment: _____

Possible side effects: i.e.: *no peanut products allowed* _____

Program modification: _____

When to call parent/health care provider regarding symptoms or failure to respond to treatment: _____

When to consider what condition requires urgent care or reassessment: _____

Physician's Name: _____

Physician's Signature: _____ Date: _____