Individual Child Care Program Plan (ICCPP)for Allergies / Severe Allergies

Form I-200

Child's Name: Date of Birth Allergy To: Specific Triggers: ☐ eating ☐ breathing (inhalation) ☐ touching ☐ insect bite other (specify):	Place Child's Picture Here

Signs of an allergic reaction include:

System	Symptoms
Mouth	Itching and swelling of the lips, tongue or teeth
Throat *	Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
Skin	Hives, Itchy rash and/or swelling about the face or extremities
Gut	Nausea, abdominal cramps, vomiting and/or diarrhea
Lung*	Shortness of breath, repetitive coughing and/or wheezing
Heart*	"weak pulse" or "passing out"

life threatening

INSTRUCTIONS FROM A HEALTH CARE PROVIDER

Medication Instructions:

1. Name/Dosage: for described symptoms
2. Name/Dosage: for described symptoms
3. Name/Dosage: for described symptoms

***If Epinephrine is used call 911**

****Anaphylaxis is a potentially life threatening severe allergic reaction. If in doubt give epinephrine.**

Provider Signature: **Date:**

EMERGENCY PHONE NUMBERS

Parent/Guardian #1 - Name, Phone:

Parent/Guardian #2 - Name, Phone:

Primary health care provider's name and phone: **Specialist name and phone, if any:**

I give my permission for the child care provider to follow the plan of care prescribed by the health care provider. I also give my permission to share my child's information with emergency responders. I understand that a photo of my child including my child's name and specific allergies and treatment will be posted and visible to others in the program.

Parent/Guardian Signature: **Date:**

-Over-

Individual Child Care Program Plan (ICCPP) for Allergies/Severe Allergies - Page 2

Form I-100

Child Name/Date of birth:

TO BE COMPLETED BY CHILD CARE PROVIDER

Techniques to avoid exposure:

Who will take charge of the situation if a reaction occurs?

Where will the medications needed for a reaction be kept? (recommend in the same location as the child)

Where in the program will the child receive care when a reaction occurs?

What will the staff do if the child is:
...on the playground?

...on a field trip?

Where will the medications be kept while on a field trip?

Who will call 911?

Who will call the parent/guardian?

Who will go with the child to the hospital and stay until the parents can assume responsibility?

Who will care for the other children if the caregiver must take the allergic child away from the group?

Is the allergy information available where food is prepared and served? YES ◯ NO ◯

TRAINED CHILD CARE PROVIDERS: **(full printed name, signature and date trained)**

*Must be reviewed with any changes to the plan. If needed, attach more signatures to form:

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

Date current ICCPP was created:

Plan of care written in collaboration with: (Director/Center Representative)

Projected date of plan of re-evaluation (done at least yearly):