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.**

Health Care 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:**