SPECIAL NEEDS PLAN FOR A CHILD

WITH ENVIRONMENTAL OR SEASONAL ALLERGIES

Child's Name: ________________________________ Child's DOB: ____________________

Does this child have asthma? **Yes** **No** Child's Weight: ____________________

This plan is designed to be completed for a child with seasonal/environmental allergies that are not life threatening and do not require emergency medication. *By completing this form, staff will have a better understanding of the child's allergy, including triggers, symptoms and what treatment may be required. Any required medication will be stored per the programs approved Health Care Plan.*

- The abovenamed child has a diagnosis of (please circle):
  Seasonal Allergies **Environmental Allergies** Other: ___________________

- Is the child on **medication** for the allergy? **Yes** **No**
  - If you answered **Yes** above, is the medication needed in care? **Yes** **No**

    *See written Medication Consent form for medication(s) needed in care.
  - Is this medication an emergency medication (Epinephrine, Diphenhydramine, Inhaler, Nebulizer)? **Yes** **No**

    *If you answered **Yes** above, you must complete the **OCFS-LDSS-6029**

- **Known triggers** for child's allergy (circle all that apply):

Animals/Pet Dander Chemical Odors Flowers Grass Dust Mold
Perfumes/Scents Season Changes (Specify: __________________) Pollen
Other: ____

- Typical **signs & symptoms** the child experiences with the allergy (circle all that apply):

Runny Nose Sneezing Coughing Congestion Itchy/watery eyes Puffy eyes
Itchy Throat Post-Nasal Drip Other: ____

Do you consider these signs/symptoms to be **mild or severe**? ________________________

How frequent are these symptoms? **Daily** **Intermittent** **Infrequent**

- Strategies to reduce the risk of exposure to the child's known triggers include:
  ____

____

____

____

- Are there any accommodations needed in care for the child or special instructions for staff (explain below or write N/A):____

____
____
____
____

- The program staff who will care for the child with special health care needs are:

Staff:	Credentials:
____________________________________	____________________________
____________________________________	____________________________
____________________________________	____________________________
____________________________________	____________________________

- Does staff need any additional training to care for the child? **Yes** **No**
    - **If Yes, specify:** ____

- Reasons to contact the parent: _______________________________________
- **Reasons to call 911**: Difficulty breathing or signs/symptoms of anaphylaxis.

This plan was developed in close collaboration with the child's parent/guardian and the child's health care provider. The program understands their responsibility to follow this plan and assure that the caregivers listed above understand the plan, as well as maintain the appropriate credentials needed to care for the child.

Child's Health Care Provider: ____________________________ Phone #:_________________
Health Care Provider Signature: ____

Provider/Program Name: ____
License/Registration #: ________________ Program Telephone #: ______________________
Child Care Provider's Name (please print): ____
Child Care Provider's Signature: ____________________________________ Date: __________

Name of Parent/Guardian: _________________________________ Phone #: _______________
Signature of Parent/Guardian: ____________________________________ Date:____________