

**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: _____