MONTESSORI EDUCATION CENTER of HAWAII, INC.

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: _____

Program modification: *i.e.: no peanut products allowed.* _____

_____

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: _____

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