Capital Area Head Start

It takes a community to raise a child
Keystone Human Services

Allergy/Intolerance Care Plan

This form MUST be completed by a physician and returned to CAHS prior to child's start in classroom/center.

Child: _____ Date of Birth: _____

Parent's Name: _____

Center Child Attends: _____ Classroom: _____

- Please list what the child is allergic to: _____
  List the **symptoms** and **severity** of the reaction when this child ingests or comes into contact with allergen(s)?
  _____

- **IF THIS IS A FOOD ALLERGY or INTOLERANCE**, please list all food(s) that must be excluded and/or substituted for this child while in class. CAHS cannot deprive children of meal components due to allergies or intolerances. *Please be specific*, as some children can be served certain foods, but not others (ex: child cannot drink liquid milk, but tolerates cheese and yogurt without issue):
  - **Food(s) that must be excluded from child's diet:** _____
    _____
  - **Food(s) that must be substituted:** (i.e**., lactose intolerance** – what dairy alternative must be served? Rice milk, Soy milk, etc.)
    _____
    _____

- Does this child take any medication for their allergy? Check one: _____ YES _____ NO
  - Medication: _____
  - Dosage: _____
  - Frequency: _____

- What course of action should Head Start teachers/staff take if this child has an allergic reaction while in our care? Please **describe them in detail**:
  _____
  _____
  _____

- Any additional information you feel may be beneficial for CAHS to know about this child's allergy:
  _____
  _____

Physician's Name:_____ Signature: _____

Address: _____ Phone Number: _____

Date of Plan: _____