OCFS-LDSS-7006

Allergy Action Plan

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Working in collaboration with the child's parent/guardian and child's health care provider, the following health care plan was developed to meet the individual needs of:

Child's Name:	Child's date of birth:
Name of the child's health care provider:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Allergy to:
If possible plan to avoid allergy exposure:

◯ **Check if the child has asthma and is at a greater risk for a severe reaction.**

MILD symptoms may include: Itchy mouth, a few hives around the mouth or face, mild itch, vomiting or cramping

Check if the doctor has indicated to give Diphenhydramine/ Benadryl for:
◯ ANY symptoms if the allergen was likely eaten.
◯ If the allergen was defiantly eaten, even if NO symptoms are noted.
◯ If there was an exposure and the following symptoms are observed:

Medication and Strength_____Dose_____

Remain with the child, and notify the parent. Begin monitoring for worsening symptoms.

SEVERE Symptoms may include: Shortness of breath, wheeze, repetitive cough, pale/ blue color, weak pulse, dizziness, confusion, tight or hoarse throat, difficulty breathing/ swallowing, obstructive swelling (tongue/ lips) many hives over the body.
OR a combination of symptoms from **different body areas** such as:
(Skin) itchy rash, hives, swelling of the eyes or lips **and** (Gut) vomiting, craping pain.

Check if the doctor has indicated to give Epinephrine/ Epi Pen/ Auvi-Q immediately for:
◯ ANY symptoms if the allergen was likely eaten.
◯ If the allergen was defiantly eaten, even if NO symptoms are noted.
◯ If there was an exposure and the following symptoms are observed:

Medication and Strength_____Dose_____

If epinephrine was administered call 911 immediately and notify the parent. Remain with the child and alert the emergency responders that epinephrine was given and note the time. Consider allowing the child to lye on their back with legs raised.

◯ **Check if the doctor indicated a second dose of epinephrine can be given after ____ minutes if symptoms persist or reoccur.**

Identify the program staff who will provide care to this child with special health care needs:

Name	Credentials or Professional License Information*

This is a double-sided form

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Continued

Describe any additional training, procedures or competencies the staff identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

Date _____ Parent provided training on the specific needs of _____ pertaining to the child's allergy needs and the individual health care plan.
The following staff were present:

If staff that are <u>not</u> MAT trained may administer the medication:
Date_____ Training was provided by
(Circle one) The parent, an authorized health care provider, or the health care consultant

Name of person providing training: _____
On the proper administration of the medication to the following staff:

Signature of Authorized Program Representative:

I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child's parent and the child's health care provider. *I understand that it is my responsibility to see that those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR and first aid certifications or have a license that exempts them from training; and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Provider/Facility Name:	Facility ID Number:	Facility Telephone Number:
Authorized child care provider's name (please print):		Date:
Authorized child care provider's signature:		

Signature of Parent or Guardian:

	Date: