

# Allergy Emergency Plan

*This plan must be signed and dated by your child's Health Care Professional*

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Doctor: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

## **Please complete ONE form for each known Allergy**

Possible symptoms if exposed to the Allergy -

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Specific steps to take if the child has an allergic reaction -

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**By signing below, the Parent or Guardian of this child allows Early Care & Education center permission to post the child's allergy in the required areas of the facility.** (Classrooms, Food Service/Prep area, Emergency evacuation folder, Transport and Field Trip folder)

Dr. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent /Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Center Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_