Individual Care Plan

_____Allergy _____Respiratory _____Other

Patient Name:

Patient DOB:

Address:

Physician's Name: Physician's #:

Diagnosis:

Asthma: Yes / No

Specific Allergen:

Food Allergy: Touch: Ingestion: Aromatic:

IF CHILD INGESTS OR THINKS HE/SHE INGESTED THE ABOVE-NAMED FOOD, HAS HAD CONTACT WITH THE ABOVE-NAMED FOOD, OR IF CHILD IS STUNG FOLLOW THE NUMBER OF SEQUENCE OF ADMINISTRATION OF MEDS:

_____ GIVE _____MGS (_____TSP) OF BENADRYL

_____ OBSERVE CHILD FOR SIGNS AND SYMPTOMS

_____ GIVE EPI-PEN JR 0.15MG OR EPI-PEN .3MG OR AUVI–Q.1MG BEFORE SYMPTOMS OCCUR. CALL 9-1-1

_____ GIVE EPI-PEN JR 0.15MG OR EPI-PEN .3MG OR AUVI-Q .1MG IF SYMPTOMS OCCUR. CALL 9-1-1

_____ TRANSPORT TO ER VIA 9-1-1

_____ _____

Parent signature and date Physician's Signature and date

****

EMERGENCY PHONE NUMBERS:

Name	Relationship	Phone #
1.		
2.		