CDC
CHILD DEVELOPMENT CENTER
PO Box 1117 1602 W. Ferguson Rd
Mt. Pleasant TX 75455
(903)575-2092 fax (903)575-2077

Year: _____

Allergy Care Plan

Child's name/*Nombre del Niño*	Birthday/*Fecha de Nacimiento*	Room/Salón

To be filled out by parent:

Parent/Guardian Name: _____ Phone number: _____

Doctor: _____ Address: _____ Phone number: _____

Hospital: _____ Address: _____ Phone number: _____

☐My child does NOT have any allergies/*Mi hijo(a) no tiene alergias*

☐My child is allergic to/*Mi hijo(a) es alergico a*:_____

Is this allergy diagnosed by a doctor/*La alergia es diagnosticada por un doctor*: ☐Yes ☐No

If no, what is the usual treatment used at home*/Si no, cual es el tratamiento usual en casa*:_____

If yes have doctor fill out the following section/*Si respondio si el doctor llenara la siguiente seccion*.

Doctor to complete:

Allergy: _____

□Redness around the bite/sting	□Hives on the body
□Itching around the bite/ sting	□Swelling in the throat or tongue
□Pain around the bite/ sting	□Difficulty breathing
□Swelling around the bite/sting	□Dizziness

□Other(explain):_____

Emergency Treatment Plan: _____

_____

Nurse's Comments: _____

I give the school permission to administer the allergy care plan.

Parent or Guardian Signature/*Firma del Padre o Tutor*: _____ Date: _____

Doctor Signature/*Firma del Doctor*: _____ Date:_____

Teacher Signature/*Firma del Maestro(a):* _____ Date: _____

Cafeteria Manager Signature/*Firma del Gerente de Cafeteria*: _____ Date: _____

Health Staff Signature/*Firma de Personal de Salud*: _____ Date: _____