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
- ☐Itching around the bite/ sting
- ☐Pain around the bite/ sting
- ☐Swelling around the bite/sting
- ☐Hives on the body
- ☐Swelling in the throat or tongue
- ☐Difficulty breathing
- ☐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: _____________

Revision 2025