



Food Allergy Emergency Plan

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

Child's Name: _____ Date of Birth: _____

Doctor: _____

Dr. Address: _____

Dr. Phone: _____

Please complete one form **FOR EACH** known food allergy.

Food child is allergic to: _____

Possible symptoms if exposed to this food: _____

Specific steps to take if the child has an allergic reaction to the above listed food: _____

Dr. signature: _____ Date: _____

Parent or guardian signature: _____

Center director signature: _____

For center use only:

_____ Food Allergy PLAN REQUIRED tracking bit set in child's file

_____ Food Allergy Emergency Plan has been scanned and attached to child's file

_____ Food Allergy Emergency Plan has been printed and placed in kitchen, café and classrooms

_____ Food Allergy Emergency Plan has been printed and placed in evacuation binder