**INDIVIDUALIZED MEDICAL NEEDS PLAN FOR A CHILD WITH A**

**NON-LIFE-THREATENING ALLERGY OR FOOD RESTRICTION**

Photo of Child (Recommended)

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| Child’s Name: |
| Child's Date of Birth (dd/mm/yyyy): |
| **Date Individualized Plan Completed**(dd/mm/yyyy): |

**ALLERGEN(S) or CAUSATIVE AGENT(S):**

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| SIGNS AND SYMPTOMS OF REACTION: |
| PROCEDURE TO FOLLOW IF REACTION OCCURS: |
| ALTERNATIVE SUGGESTIONS: |
| SUPPORTS AVAILABLE TO THE CHILD: |
| STEPS TO FOLLOW IN AN EVACUATION OR ON AN OFF-SITE FIELD TRIP: |

**Additional Information Related to the Medical Condition (if applicable):**

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This plan has been created in consultation with the child’s parent / guardian.

**Parent/Guardian Signature:**

|  |  |
| --- | --- |
| **Print name:** | **Relationship to child:** |
| **Signature:** | **Date** (dd/mm/yyyy): |

The following individuals participated in the development of this individual plan (optional):

|  |  |  |
| --- | --- | --- |
| First and Last Name | Position/Role | Signature |
|  |  |  |

This plan will be reviewed and updated annually or more frequently if required.