Public Health
Seattle & King County

Health Care Provider's Allergy/Intolerance Report

Name of Child _____ **Child's Date of Birth** _____

This child is enrolled in our child care program. We have been advised that he/she is allergic or intolerant to the following items:

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

As a licensed child care program we are required to meet state licensing standards. Please help us to comply and meet the health needs of your patient by completing the Allergy/Intolerance Statement form, the Child Care Emergency Plan for Allergic Reactions, and if necessary the Allergy Medication Authorization Form. We need to know which items the child is allergic or intolerant to, the steps to take to treat an allergic reaction, and appropriate substitute foods to assure that the child's nutrition is not compromised.

Thank you for your help in this important health matter. *Please return completed packet to the Child Care site listed below.*

Sincerely,

Child Care Program Director _____ **Child Care Site Name** _____

Mailing Address:

_____
Street Address

_____ **Phone:** _(____)_____
Suite, PO BOX

_____ **Fax:** _(____)_____
City, State, and Zip Code

By signing below, I indicate my approval to release the information requested above to my child's child care program.

Parent/Guardian Name (printed) _____ **Parent/Guardian Signature** _____ **Date** _____

(____)_____
Parent Phone Number

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Allergy/Intolerance Statement

Name of Child _____ Child's Date of Birth _____

(Please print)

Food Allergy List each food separately	Check the medical condition	List appropriate substitute food(s)
	Food Intolerance ☐ Yes ☐ No Food Allergy ☐ Yes* ☐ No	
	Food Intolerance ☐ Yes ☐ No Food Allergy ☐ Yes* ☐ No	
	Food Intolerance ☐ Yes ☐ No Food Allergy ☐ Yes* ☐ No	
	Food Intolerance ☐ Yes ☐ No Food Allergy ☐ Yes* ☐ No	

Other Allergy Please list type:	Reaction: Mild ☐ Yes ☐ No Severe ☐ Yes ☐ No	Plan for management:

*** For an Allergy, please complete the Child Care Emergency Plan for Allergic Reactions.**

Health Care Provider Name (please print): X _____

Health Care Provider Signature: X _____ **Date:** X _____

_____
Street Address

_____ **Phone:** _(____)_____
Suite, PO BOX

_____ **Fax:** _(____)_____
City, State, and Zip Code

Please return completed packet to the child care program at the mailing address listed on Page 1.

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Child Care Emergency Plan for Allergic Reactions

ALLERGY TO: _____

Child's Name: _____ **Date of Birth:** _____

Asthma? **Yes*** ☐ **No** ☐ *High Risk for severe reaction

SIGNS OF AN ALLERGIC REACTION:

Systems	Symptoms
• MOUTH	itching & swelling of the lips, tongue, or mouth
• THROAT	itching and/or a sense of tightness in the throat, hoarseness and hacking cough
• SKIN	hives, itchy rash, and/or swelling about the face or extremities
• GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
• LUNG	shortness of breath, repetitive coughing, and/or wheezing
• HEART	"thready" pulse, "passing-out"

The severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation.

Action for *minor* reaction:

If symptom(s) are: _____

☐ **Administer:** _____
medication/ dose /route

☐ **Then call: Parent/Guardian and Health Care Provider**

☐ **If condition does not improve within 10 minutes, follow steps for *severe* reaction below:**

Action for *severe* reaction:

If symptom(s) are: _____

☐ **Administer:** _____ **IMMEDIATELY!**
medication/ dose /route

☐ **Call:** **911 (Never hesitate to call 911)**

☐ **Call:** **Parent or Guardian**

☐ **Call:** **Health Care Provider**

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. (This authorization is for a maximum of one year from signature date.)

X_____ _(____)_____
Health Care Provider Name (printed) Phone Number

X_____ X_____
Health Care Provider Signature (required) Date

Parent/Guardian: I agree with the above allergy emergency care plan. I will inform the child care program if child's health status/medication changes.

_____ _(____)_____
Parent/Guardian Name (printed) Phone Number

_____ _____
Parent/Guardian Signature Date

Emergency Contact Information

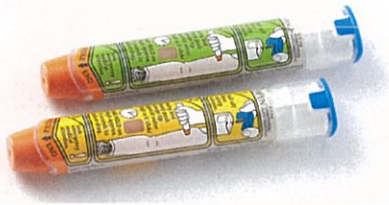
Emergency Contact #1	Phone:
Name: _____ Relation: _____	(____)_____
Emergency Contact # 2	**Phone:**
Name: _____ Relation: _____	(____)_____
Emergency Contact # 3	**Phone:**
Name: _____ Relation: _____	(____)_____

Staff Training Information

Staff Name	Trainer (parent or guardian)	Date

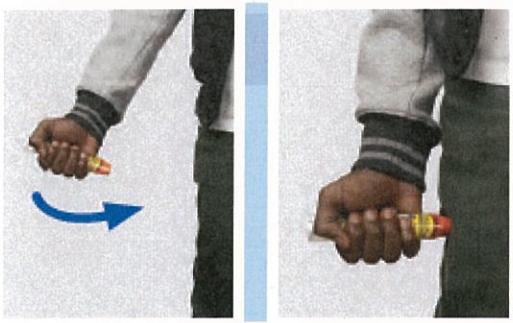
Epinephrine auto-injections come in different forms. Always follow the instructions given in the parent/guardian's training and included on the injection device itself. Instructions may differ by brand, dose, etc. Below are two common types of epinephrine auto-injectors.

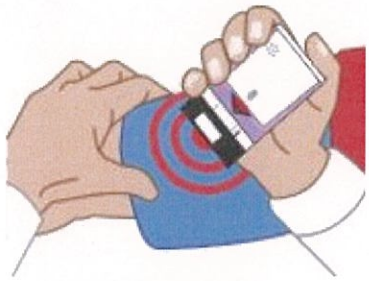
EPIPEN® and EPIPEN® Jr.



AUVI-Q®

Always apply to the middle of the outer thigh and hold firmly in place (see medication instructions for how long injection should be held).





Once injected, remove epinephrine injector and take it with you to the Emergency Room.

Allergy Medication Authorization Form

Child's Name:	Date of Birth/Age:
Type of Allergy:	
Name of Medication: **antihistamine**	Amount/Dose:
Medication Start Date: ___/___/___	Medication Expiration Date = Stop Date: ___/___/___
Times to be given: **"See Care Plan"**	Route: ☒ Oral ☐ Topical ☐ Other
Possible Side Effects:	Requires Refrigeration: ☐ Yes ☒ No
☐ Above information consistent with label?	Special Instructions:
Name of Medication: **epinephrine auto-injector (EpiPen)**	Amount/Dose:
Medication Start Date: ___/___/___	Medication Expiration Date = Stop Date: ___/___/___
Times to be given: **"See Care Plan"**	Route: ☐Oral ☐Topical ☒Other: injection
Possible Side Effects:	Requires Refrigeration: ☐ Yes ☒ No
☐ Above information consistent with label?	Special Instructions:

_____ _(___)_____
Health Care Provider Name (please print) Phone Number

X_____ X_____
Health Care Provider Signature Date

_____ _(___)_____
Parent/Guardian Name (please print) Phone Number

_____ _____
Parent/Guardian Signature Date

Child Care Program Staff: This form is active or a maximum of one year from health care provider's signature date (above), and should be renewed annually, or sooner if there are changes to medication or health condition.
Authorization form is active from: ___/___/___ **to** ___/___/___.

Medication Record

Medication: antihistamine

Allergy Reaction Documentation:

Symptoms Observed:_____

Time symptoms began:_____

Time **antihistamine** given:_____

Time parent/Guardian called:_____

Symptoms resolved (10 minutes) or worsened? _____

Action taken:_____

Date	Time	Dosage	Initials	Reason NOT Given	*Side Effects Observed*

Medication: epinephrine auto-injector

Allergy Reaction Documentation:

Symptoms Observed:_____

Time symptoms began:_____

Time **epinephrine auto-injector** was given:_____

Time 911 called:_____

Time parent/guardian called: _____

Time Health Care Provider called:_____

Child taken:_____(where) by _____(whom).

Date	Time	Dosage	Initials	Reason NOT Given	*Side Effects Observed*

Initials and Signatures of persons giving medication:

_____ _____ _____ _____

_____ _____ _____ _____