



**Health Care Provider's
Allergy/Intolerance Report**

Name Of Child

Today's Date

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. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

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 and if necessary the Child Care Emergency Plan for Allergic Reactions. 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.
Sincerely,

Child Care Program Director

Child Care Site

Child Care Center Address

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

Parent/Guardian Signature

Date

Parent/Guardian Name (print)

Parent/Guardian Address



Name of Child _____ Birthdate _____

(Please print)

Food Allergy: List each food separately	Check the medical condition	List appropriate substitute food(s)
	Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Yes No Food Allergy <input type="checkbox"/> <input type="checkbox"/> *Yes No	
	Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Yes No Food Allergy <input type="checkbox"/> <input type="checkbox"/> *Yes No	
	Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Yes No Food Allergy <input type="checkbox"/> <input type="checkbox"/> *Yes No	
	Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Yes No Food Allergy <input type="checkbox"/> <input type="checkbox"/> *Yes No	

Other Allergy: Please list items:	Reaction: Mild <input type="checkbox"/> <input type="checkbox"/> Yes No Severe <input type="checkbox"/> <input type="checkbox"/> Yes No	Plan for management:
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*** For an Allergy, please complete the Child Care Emergency Plan for Allergic Reactions.**

Health Care Provider Name _____

Health Care Provider Signature _____ Date _____

Mailing Address (Print) _____ Phone _____

Please return to the child care program at the address listed below:



Child Care Emergency Plan for Allergic Reactions

ALLERGY TO: _____

Student's Name: _____ D.O.B.: _____

Asthma Yes* No *High Risk for severe reaction

SIGNS OF AN ALLERGIC REACTION:

Systems

- MOUTH
- THROAT
- SKIN
- GUT
- LUNG
- HEART

Symptoms

itching & swelling of the lips, tongue, or mouth
 itching and/or a sense of tightness in the throat, hoarseness and hacking cough
 hives, itchy rash, and/or swelling about the face or extremities
 nausea, abdominal cramps, vomiting, and/or diarrhea
 shortness of breath, repetitive coughing, and/or wheezing
 "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**

Parent/guardian name _____ phone # _____

Parent/guardian signature _____ Date: _____

Health Care Provider name _____ phone # _____

Health Care Provider signature (Required) _____ Date: _____



Emergency Contacts

1. _____

Relation: _____ Phone _____

2. _____

Relation: _____ Phone _____

3. _____

Relation: _____ Phone _____

Trained Staff Members

1. _____ Room _____

2. _____ Room _____

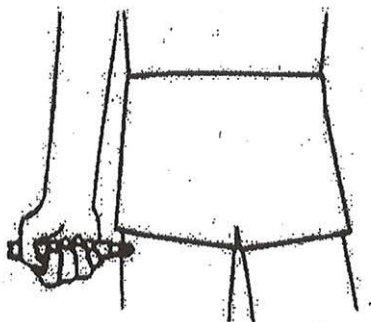
3. _____ Room _____

EPIPEN® and EPIPEN® Jr. Directions

1. Pull off blue safety release.



2. Hold orange tip near outer thigh (always apply to thigh).



3. Place firmly against thigh and press until Auto-injector mechanism functions. Hold in place and count to 10. The EpiPen unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 20 seconds.

Allergy Medication Authorization Form

Child's Name:	Date of Birth:
Type of Allergy:	Age _____ and Weight _____

Name of Medication: Antihistamine	Amount/Dose:
Start Date:	Stop Date:
Times to be given: "See Care Plan"	Route: Oral
Possible Side Effects:	Special Instructions:
<input type="checkbox"/> Above information consistent with label?	Requires Refrigeration: <input type="checkbox"/> yes X no

Name of Medication: EpiPen	Amount/Dose:
Start Date:	Stop Date:
Times to be given: "See Care Plan"	Route: Injection
Possible Side Effects:	Special Instructions:
<input type="checkbox"/> Above information consistent with label?	Requires Refrigeration: <input type="checkbox"/> yes X no

 Health Care Provider Signature Date

 Health Care Provider Name Phone Number

 Parent/Guardian Signature Date

 Parent/Guardian Name (1) Phone Number

 Parent/Guardian Name (2) Phone Number



Medication Record

Medication: Antihistamine

Allergy Reaction Documentation:

1. Symptoms Observed: _____
2. Time symptoms began: _____
3. Time Antihistamine given: _____
4. Time parent/Guardian called: _____
5. Symptoms resolved (10 minutes) or worsened? _____
6. Action taken: _____

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Medication: EpiPen

Allergy Reaction Documentation:

7. Symptoms Observed: _____
8. Time symptoms began: _____
9. Time EpiPen given: _____
10. Time 911 called: _____
11. Time parent/guardian called: _____
12. Time Health Care Provider called: _____
13. Child taken: _____ (where) by _____ (whom).

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Initials and Signatures of persons giving medication:

