Public Health
Seattle & King County

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 _____

_____

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Name of Child _____ Birthdate_____

(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 items:	**Reaction:**	**Plan for management:**
	Mild ☐ Yes ☐ No Severe ☐ Yes ☐ No	

*** 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:

_____

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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	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**

Parent/guardian name _____ phone # _____

Parent/guardian signature _____ Date: _____

Health Care Provider name _____ phone # _____

Health Care Provider signature (Required) _____ Date: _____

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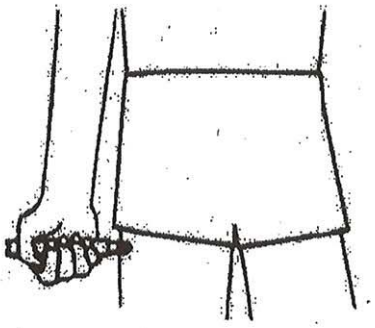
Emergency Contacts	Trained Staff Members
1. _____	1._____Room_____
Relation:_____Phone_____	2._____Room_____
2. _____	3._____Room_____
Relation:_____Phone_____	
3. _____	
Relation:_____Phone_____	

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. <u>Hold</u> <u>in place and count to 10</u>. The EpiPen unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 20 seconds.

Child Care Health Program
401 Fifth Avenue, Suite 1000
Seattle, WA 98104
206-263-8262 Fax 206-205-6236
TTY Relay: 711
www.kingcounty.gov/health

Public Health
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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;
☐ Above information consistent with label?	Requires Refrigeration: ☐ 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:
☐ Above information consistent with label?	Requires Refrigeration: ☐ 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:

_____ _____ _____ _____