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 ______________________________

____

Public Health
Seattle & King County

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:** 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 ____

Health Care Provider Signature ____________________________ Date ____________

Mailing Address (Print) Phone ______________________

____

____

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

____

Public Health
Seattle & King County

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: ______________

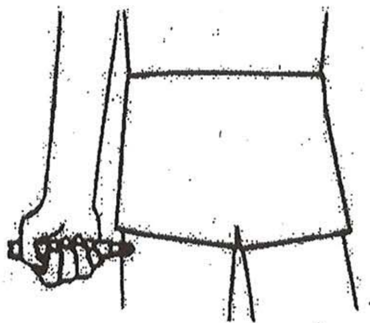
Public Health
Seattle & King County

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 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
Seattle & King County

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

08/01/2011

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:

________ ______________________________ ________ ______________________________