

Health Care Provider's Allergy and Intolerance Form

Name of Child

Child's Date of Birth

The above child attends our child care program and we have been 'informed' that they are 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 complete the Allergy and Intolerance Statement, 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.**

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, Zip Code

By signing below, I indicate my approval to release the information requested above to my child's child care/early learning program to be completed as appropriate in pages 2-7 of this form.

Parent/Guardian Name (Printed)

Parent/Guardian Signature

Date

Parent/Guardian Phone Number

Allergy and Intolerance Statement

Name of Child Child's Date of Birth

FOOD INTOLERANCES (list each food separately)		
1.	Appropriate Substitute Food(s)	
2.	Appropriate Substitute Food(s)	
3.	Appropriate Substitute Food(s)	
FOOD ALLERGIES* (list each food separately)		
1.	Severity of Reaction <input type="checkbox"/> Mild <input type="checkbox"/> Severe	Appropriate Substitute Food(s)
2.	Severity of Reaction <input type="checkbox"/> Mild <input type="checkbox"/> Severe	Appropriate Substitute Food(s)
3.	Severity of Reaction <input type="checkbox"/> Mild <input type="checkbox"/> Severe	Appropriate Substitute Food(s)
NON-FOOD ALLERGIES* (list each separately)		
1.	Severity of Reaction <input type="checkbox"/> Mild <input type="checkbox"/> Severe	Additional Provider Notes
2.	Severity of Reaction <input type="checkbox"/> Mild <input type="checkbox"/> Severe	Additional Provider Notes

***For ANY allergy requiring emergency medication(s), please complete and follow the "Child Care Emergency Plan for Allergic Reactions" on page 3.**

X _____
Health Care Provider Name (Printed)

X _____
Health Care Provider Signature Date

Street Address Phone: _____

Suite, PO Box Fax: _____

City, State, Zip Code

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

Child Care Emergency Plan for Allergic Reactions

Name of Child Child's Date of Birth

Allergy to: _____

Does the child also have Asthma? No Yes (higher risk for severe reaction)

SIGNS OF AN ALLERGIC REACTION

<u>Body System</u>	<u>Symptoms*</u>
• 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 around the face or extremities
• Gut	Nausea, abdominal cramps, vomiting, and/or diarrhea
• Lungs	Shortness of breath, repetitive coughing, and/or wheezing
• Heart	"thready" pulse, "passing-out"

*The severity of any symptom(s) can change quickly and progress to a life-threatening situation.

Action for **any allergic** reaction:

- Administer:** Epinephrine _____ **IMMEDIATELY!**
(medication, dose, route)
- Call: 911 (Never hesitate to call 911)**
- Call: Parent/Guardian**
- If the child's symptoms have **NOT** improved after **10** minutes, administer a second dose of epinephrine, if one is available, per instructions in **Step 1 above**.

Additional Actions (as ordered by Health Care Provider):

- Administer:** Antihistamine _____
(medication, dose, route)
- _____

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

X _____
Health Care Provider Name (Printed)

X _____
Health Care Provider Signature

Date

Parent/Guardian: I agree with the Child Care Emergency Plan for Allergic Reactions. I will inform the child care program if child's health status/medication changes.

Parent/Guardian Name (Printed)

Parent/Guardian Signature

Date

Parent/Guardian Phone Number

Emergency Contact Information

Emergency Contact #1 Name: _____ Relationship: _____	Phone: _____
Emergency Contact #2 Name: _____ Relationship: _____	Phone: _____
Emergency Contact #3 Name: _____ Relationship: _____	Phone: _____

Staff Training Record*

Staff Name	Trainer (Parent/Guardian Signature)	Date

***Per WACs 110-300-0215 and 110-300-0186, an Early Learning provider must work with the child's parents or guardians to ensure the program has the necessary medication, training, and equipment to properly manage a child's food allergies. Annual staff training is NOT sufficient. Staff should receive individualized training from a parent/guardian for each child that has an allergy care plan.**

Allergy Medication Authorization Form

X This form is valid from: / / (Start Date) until / / (End Date).
(Health Care Providers: End date is a maximum of one year from your signature date **below**)

Child Care Program Staff: A **new** Allergy Care Plan should be completed and signed by the “End Date” (shown above), or sooner if there are changes to a medication or health condition. If a medication expires before the “End Date of this Authorization Form, a health care provider or parent/guardian does not need to complete a new form, but the expired medication **MUST** be replaced with one that has not expired. **Never give an expired medication.**

Child’s Name:	Date of Birth:
Type of Allergy:	
Name of Epinephrine Auto-Injector:	Amount/Dose:
Epinephrine Auto-Injector Expiration Date: <u> </u> / <u> </u> / <u> </u>	
Times to be given: See “Child Care Emergency Plan for Allergic Reactions”	Route: <input type="checkbox"/> Injection
Possible Side Effects:	Requires Refrigeration: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Above information is consistent with label	Special Instructions:
Name of Antihistamine (if ordered):	Amount/Dose:
Antihistamine Expiration Date: <u> </u> / <u> </u> / <u> </u>	
Times to be given: See “Child Care Emergency Plan for Allergic Reactions”	Route: <input type="checkbox"/> Oral <input type="checkbox"/> Topical
Possible Side Effects:	Requires Refrigeration: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Above information is consistent with label	Special Instructions:

X _____
Health Care Provider Name (Printed)

X _____
Health Care Provider Signature

Date

Parent/Guardian Name (Printed)

Parent/Guardian Signature

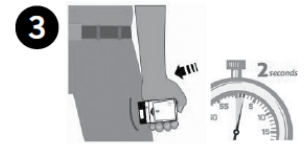
Date

There are many different types of Epinephrine auto-injectors. **Always follow the instructions on the medication label, as well as any child-specific instructions from parents/guardians.**

Below are common types of epinephrine auto-injectors and how to use them. **These instructions DO NOT replace staff training by the parent/guardian.**

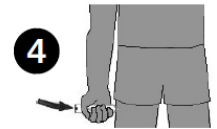
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



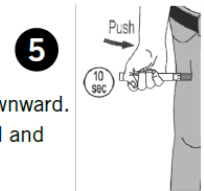
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

*Images copied from FARE (Food Allergy Research & Education) Food Allergy & Anaphylaxis Emergency Care Plan

Medication Record

Please follow ALL instructions of “Child Care Emergency Plan for Allergic Reactions” on page 3 of this care plan and use this page for documentation.

1. Epinephrine Auto-Injector:

Allergy Reaction Documentation

Allergen exposed to: _____

Symptoms observed: _____

Time symptoms began: _____

Time 911 called: _____

Time parent/guardian called: _____

Symptoms resolved or worsened (within 10 minutes)? _____

Child transported to: _____ (where) by _____ (whom).

Date	Time Given	Dosage	Initials	Side Effects Observed

If epinephrine was NOT given, why?

2. Antihistamine Medication (if ordered by Health Care Provider):

Date	Time Given	Dosage	Initials	Side Effects Observed

If antihistamine was NOT given, why?

Initials and Signatures of persons giving medication:
