



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

| Other Allergy:<br>Please list items: | Reaction:                                                       | Plan for management: |
|--------------------------------------|-----------------------------------------------------------------|----------------------|
|                                      | Mild <input type="checkbox"/> Yes <input type="checkbox"/> No   |                      |
|                                      | Severe <input type="checkbox"/> Yes <input type="checkbox"/> 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:



## 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 \_\_\_\_\_

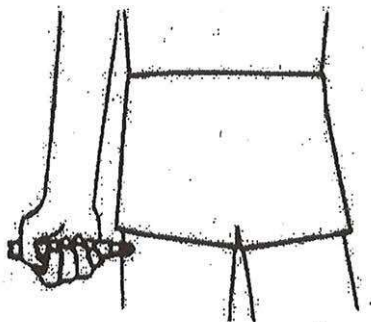
3. \_\_\_\_\_ Room \_\_\_\_\_

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

|                                                                   |                                                           |
|-------------------------------------------------------------------|-----------------------------------------------------------|
| Name of Medication: <b>EpiPen</b>                                 | Amount/Dose:                                              |
| Start Date:                                                       | Stop Date:                                                |
| Times to be given: <b>"See Care Plan"</b>                         | Route: <b>Injection</b>                                   |
| 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<br>NOT<br>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<br>NOT<br>Given | Side Effects Observed |
|------|------|--------|----------|------------------------|-----------------------|
|      |      |        |          |                        |                       |
|      |      |        |          |                        |                       |

Initials and Signatures of persons giving medication:

\_\_\_\_\_

