

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

Name of Child

Child's Date of Birth

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. _____	4. _____
2. _____	5. _____
3. _____	6. _____

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, the 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.

Thank you for your help in this important health matter. Please return completed packet to the Child Care site listed below.

Sincerely,

Child Care Program Director

Child Care Site Name

Mailing Address:

Street Address

Suite, PO BOX

City, State, and Zip Code

Phone: ()

Fax: ()

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

Parent/Guardian Name (printed)

Parent/Guardian Signature

Date

 ()
Parent Phone Number



Allergy/Intolerance Statement

Name of Child

Child's Date of Birth

(Please print)

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

Other Allergy Please list type:	Reaction: Mild <input type="checkbox"/> Yes <input type="checkbox"/> No Severe <input type="checkbox"/> Yes <input type="checkbox"/> 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 (please print): ~~X~~ _____

Health Care Provider Signature: ~~X~~ _____ Date: ~~X~~ _____

Street Address

Suite, PO BOX

City, State, and Zip Code

Phone: () _____

Fax: () _____

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



Emergency Contact Information

Emergency Contact #1	Phone:
Name: _____	_____ () _____
Relation: _____	
Emergency Contact # 2	Phone:
Name: _____	_____ () _____
Relation: _____	
Emergency Contact # 3	Phone:
Name: _____	_____ () _____
Relation: _____	

Staff Training Information

Staff Name	Trainer (parent or guardian)	Date

Epinephrine auto-injections come in different forms. Always follow the instructions given in the parent/guardian’s training and included on the injection device itself. Instructions may differ by brand, dose, etc. Below are two common types of epinephrine auto-injectors.

EPIPEN® and EPIPEN® Jr.



AUVI-Q®



Always apply to the middle of the outer thigh and hold firmly in place (see medication instructions for how long injection should be held).



Once injected, remove epinephrine injector and take it with you to the Emergency Room.



Allergy Medication Authorization Form

Child's Name:	Date of Birth/Age:
Type of Allergy:	
Name of Medication: antihistamine	Amount/Dose:
Medication Start Date: ___/___/___	Medication Expiration Date = Stop Date: ___/___/___
Times to be given: "See Care Plan"	Route: <input checked="" type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
Possible Side Effects:	Requires Refrigeration: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> Above information consistent with label?	Special Instructions:
Name of Medication: epinephrine auto-injector (EpiPen)	Amount/Dose:
Medication Start Date: ___/___/___	Medication Expiration Date = Stop Date: ___/___/___
Times to be given: "See Care Plan"	Route: <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input checked="" type="checkbox"/> Other: injection
Possible Side Effects:	Requires Refrigeration: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> Above information consistent with label?	Special Instructions:

_____ Health Care Provider Name (please print)

_____()_____ Phone Number

~~X~~_____ Health Care Provider Signature

~~X~~_____ Date

_____ Parent/Guardian Name (please print)

_____()_____ Phone Number

_____ Parent/Guardian Signature

_____ Date

Child Care Program Staff: This form is active or a maximum of one year from health care provider's signature date (above), and should be renewed annually, or sooner if there are changes to medication or health condition.

Authorization form is active from: ___/___/___ to ___/___/___.



Medication Record

Medication: antihistamine

Allergy Reaction Documentation:

Symptoms Observed: _____

Time symptoms began: _____

Time antihistamine given: _____

Time parent/Guardian called: _____

Symptoms resolved (10 minutes) or worsened? _____

Action taken: _____

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Medication: epinephrine auto-injector

Allergy Reaction Documentation:

Symptoms Observed: _____

Time symptoms began: _____

Time epinephrine auto-injector was given: _____

Time 911 called: _____

Time parent/guardian called: _____

Time Health Care Provider called: _____

Child taken: _____ (where) by _____ (whom).

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Initials and Signatures of persons giving medication:

