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

____
Suite, PO Box

____
City, State, Zip Code

Phone: ______________________________

Fax: ______________________________

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

Public Health
Seattle & King County

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** ☐ Mild ☐ Severe	**Appropriate Substitute Food(s)**
2.	**Severity of Reaction** ☐ Mild ☐ Severe	**Appropriate Substitute Food(s)**
3.	**Severity of Reaction** ☐ Mild ☐ Severe	**Appropriate Substitute Food(s)**

NON-FOOD ALLERGIES* (list each separately)		
1.	**Severity of Reaction** ☐ Mild ☐ Severe	**Additional Provider Notes**
2.	**Severity of Reaction** ☐ Mild ☐ 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

____
Suite, PO Box

____
City, State, Zip Code

Phone: ______________________________

Fax: ______________________________

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

Body System	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 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:

1. **Administer:** Epinephrine ______________________________ **IMMEDIATELY!**
   (medication, dose, route)
2. **Call: 911 (Never hesitate to call 911)**
3. **Call: Parent/Guardian**
4. 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):

5. **Administer:** Antihistamine ____
   (medication, dose, route)
6. ____

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.**

Public Health
Seattle & King County

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: ____/____/____	
Times to be given: See "Child Care Emergency Plan for Allergic Reactions"	**Route:** ☐ Injection
Possible Side Effects:	**Requires Refrigeration:** ☐ Yes ☐ No
☐ **Above information is consistent with label**	**Special Instructions:**
Name of Antihistamine (if ordered):	**Amount/Dose:**
Antihistamine Expiration Date: ____/____/____	
Times to be given: See "Child Care Emergency Plan for Allergic Reactions"	**Route:** ☐ Oral ☐ Topical
Possible Side Effects:	**Requires Refrigeration:** ☐ Yes ☐ No
☐ **Above information is consistent with label**	**Special Instructions:**

X ______________________________
Health Care Provider Name (Printed)

X ______________________________ ______________
Health Care Provider Signature **Date**

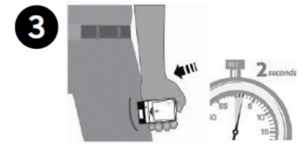
____
Parent/Guardian Name (Printed)

______________________________ ______________
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.**

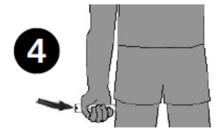
Below are common types of epinephrine auto-injectors and how to use them. **These instructions DO NOT replace staff training by the parent/guardian.**

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



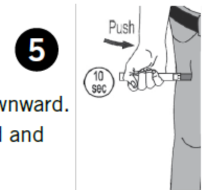
1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.

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:

________ ____________________ ________ ____________________

________ ____________________ ________ ____________________

________ ____________________ ________ ____________________

________ ____________________ ________ ____________________