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: ______________

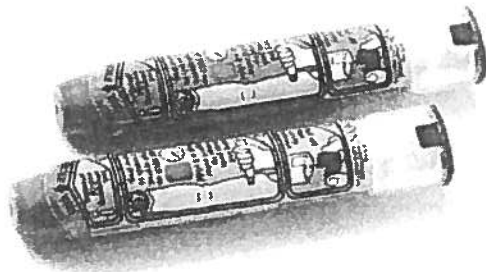
Health Care Provider name ______________________________ phone # ______________

Health Care Provider signature (Required) ______________________________ Date: ______________

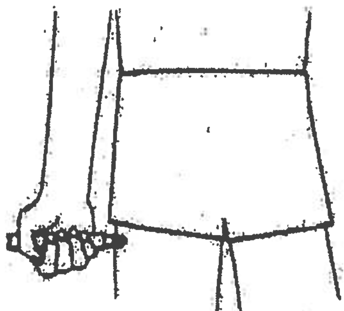
Emergency Contacts	**Trained Staff Members**
1. ______________________________	1.______________Room______
Relation:______________Phone__________	2.______________Room______
2. ______________________________	3.______________Room______
Relation:______________Phone__________	
3. ______________________________	
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:

______ ______ ______ ______