Authorization for Emergency Care Of Children with Severe Allergies

This information pertains to the 20_____ - 20_____ academic year.

Dear Health Care Provider,

Your patient, ____ is enrolled in [INSERT SCHOOL NAME] and we have been requested to provide certain emergency care for the prevention of anaphylaxis in the event th child comes into contact with a certain allergen(s), as described below. Please complete Part I of this instruction record. This record will remain in the child's file at [INSERT SCHOOL NAME] so we may assist wit the allergy care and needs of the child. If you need to provide further instructions or clarifications, please do so on a separate sheet of paper, which will become a part of this record and will be kept with this form in th child's file at [INSERT SCHOOL NAME].

PART I (to be completed by a Licensed Health Care Provider)

Child's Name:____ Child's Birth Date:______________

Known Allergens: (Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction (i.e. Anaphylactic shock) in the child.)

________ Bee Sting

________ Other Insect Bite(s): (identify):____

________ Animal(s): (identify):____

________ Food Allergy: (identify all foods or groups of foods that must be avoided):______________

____

________ Other: (identify):____

SYMPTOMS: (Please provide a complete list of all symptoms that indicate the child has come into contact with an allergen and requires emergency treatment.)

________ Shortness of Breath ________ Swelling of the Face or Lips ________ Diarrhea

________ Hives ________ Vomiting

________ Other: (explain):____

____

Individual Care Plan for Child in Child Care

Plan must be updated annually or when there is a change in the child's special need

FOOD ALLERGY and/or SPECIAL DIETARY REQUIREMENTS

This page must be completed and signed by the child's health care provider and parent or guardian.

Child's Full Name:	Today's Date:
Food the child must not consume (list each food separately)	**Appropriate substitute food(s)**

Describe allergic reactions and symptoms associated with this child's particular allergies.

Describe the treatment plan for the early learning provider to follow in response to child's allergic reaction (include names of medication, dosage amount, and directions for how to administer medication).

Other special dietary requirements due to a health condition.

Health Care Provider Signature ____________________ Date ____________

Parent or Guardian Signature ____________________ Date ____________