

Liberty Learning Centers Inc.

Child Health Plan For Food Allergy / Intolerance

Child's Name: _____ Date: _____

If there are no known allergies check box and sign below: ☐ NOT APPLICABLE

Parents Signature: _____

To be completed by parent/guardian:

My child is allergic to/has intolerance to (list all foods):

1. _____ Diagnosed by a doctor? Yes No
2. _____ Diagnosed by a doctor? Yes No
3. _____ Diagnosed by a doctor? Yes No

Which of the following happens during a reaction? (Check all that apply)

******Call parent immediately for any reaction and refer the child to a doctor******

- ☐ Hives (describe) _____
- ☐ Rash (describe) _____
- ☐ Itching (describe) _____
- ☐ Swelling (describe) _____
- ☐ Redness (describe) _____
- ☐ Tingling (describe) _____
- ☐ Stomach pain or cramps (describe) _____
- ☐ Nausea and vomiting (describe) _____
- ☐ Diarrhea (describe) _____
- ☐ Gas or bloating (describe) _____
- ☐ Other (describe) _____

CALL 911 THEN GUARDIAN FOR ANY OF THE FOLLOWING SYMPTOMS:

Two or more of the above signs
Signs above spread or worsen
Coughing or wheezing
Very warm or very cold
Trouble breathing
Weakness
Trouble swallowing or talking
Sweating
Hoarse Voice
Dizziness
Becomes pale
Confusion
Seems anxious or fearful

Passes out
Becomes unconscious
Complains of "metal" taste
Red, watery eyes
Congested, runny nose or sneezing
Head ache
Complains of chest hurting
Vomiting/diarrhea > twice
Turns blue or gray
After giving EpiPen®
If you are not sure
Other (describe)

How does your child describe the reaction when it happens?

Liberty Learning Centers Inc.

Child Health Plan For Food Allergy / Intolerance

What can we do to prevent the reaction at school/child care?

What ingredients should be avoided? (if applicable)

If your child is exposed to or eats an avoided food/ingredient, staff should:
(check one) _____ call parent _____ send note home with my child

What medication(s) does your child take at home?

Name: _____ Dose: _____ Time: _____ Side Effects: _____
Name: _____ Dose: _____ Time: _____ Side Effects: _____

What medication(s) will your child need at school/child care? (see MD Statement)

Name: _____ Dose: _____ Time: _____ Side Effects: _____
Name: _____ Dose: _____ Time: _____ Side Effects: _____

Do you want other families to know about your child's allergy? ____ Yes ____ No

Does your child have any of the following conditions? (Please circle all that apply)

Asthma

Allergies (other than food)

Eczema

Please describe:

What else should we know about your child's allergy/intolerance?

Parent/Guardian Signature: _____ Date: _____

Teacher/TA Signature: _____ Date: _____

Teacher/TA Signature: _____ Date: _____

Center Director Signature : _____ Date: _____

Copies to file, classroom, and backpack