

# 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?

\_\_\_\_\_

\_\_\_\_\_

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

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What ingredients should be avoided? (if applicable)

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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:

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

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Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher/TA Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher/TA Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Center Director Signature : \_\_\_\_\_ Date: \_\_\_\_\_

**\*Copies to file, classroom, and backpack\***