This page to be completed by:
Program Staff and Parent or Guardian

Public Health
Seattle & King County

Allergy Care Plan Request Form

Child's Name: _____

Child's Date of Birth: _____

Early Learning or Child Care Program Director: _____

Early Learning or Child Care Program: _____

Mailing Address: _____

Phone Number: _____

Fax Number: _____

Healthcare Provider: The child listed above attends our program. This packet includes forms to help meet our licensing standards for medications and care plans. **Please complete pages 2-3.** A healthcare provider is required to provide this information and sign these forms.

If the child has a diagnosed food intolerance, please contact the program listed above to request the Food Intolerance Care Plan Packet.

By signing below, I give permission to my child's healthcare provider to release the health information requested in the following care plan to my child's program.

Parent or Guardian Name (Printed): _____

Parent or Guardian Signature: _____

Date: _____

Parent or Guardian Phone Number: _____

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Date of birth: ___/___/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Attach child's photo

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine! What to do

1. Give epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine (list type): _____

Intramuscular:
☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)
(*Use 0.15 mg, if 0.10 mg is not available)

Intranasal:
☐ 1 mg (4 years or older and 15 kg to less than 30 kg)
☐ 2 mg (30 kg or more)

**If more than one epinephrine is selected, then either one can be used

Antihistamine, by mouth (type and dose): _____

Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____

Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: _____

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

 Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor. Page 2 of 2.

Public Health
Seattle & King County

Additional Requirements for Care Plans

Child's name: _____

To Program Staff and Parent or Guardian
The WAC requires that:

- All care plans include the expiration date and potential side effects of medications. **You may find this information on the medication packaging or label.**
- A parent, guardian, or appointed designee provide training to program staff about medication administration or special medical procedures listed in a child's care plan.
- A care plan lists foods that can be given in place of the child's food allergens.
- A parent or guardian provides written consent before a program can administer any medications or follow a care plan that is completed by a healthcare provider.

Use the spaces below to document the requirements listed above.

Medication Name	Expiration Date	Potential Side Effects

Employee Training Record				
Date of Training	**Employee Name (Printed)**	**Employee Signature**	**Trainer Name (Printed)**	**Trainer Signature**

Food child is allergic to:	Food substitute(s) to give instead:

By signing below, I give the program permission to follow this care plan as ordered by the healthcare provider.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

Public Health
Seattle & King County

Emergency Contact Information

Child's name: _____

Parent or Guardian: If your child has a medical emergency, program staff need to be able to contact you or another emergency contact as quickly as possible. Please complete the following:

Emergency Contact #1

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #2

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #3

Name: _____

Relationship to Child: _____

Phone Number: _____

This page to be completed by:
Program Staff

Public Health
Seattle & King County

Medication Log

Program Staff: Please print a copy of this Medication Log for each medication in the care plan.

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Date	Time	Dose	Person Giving Medication (*Initials)	Reason Medication Was Not Given	Observed Side Effects

Initials*	Printed Name and Signature of Person Giving Medications