Bellevue Children's Academy

Allergy/Intolerance Report *and* Emergency Plan for Allergic Reaction Form

THE HEALTH CARE PROVIDER'S ALLERGY/INTOLERANCE REPORT

____ ____________________

Student's Name Date

This child is enrolled in our child-care program. We have been advised that he or she is allergic or intolerant to the following items:

1.____________________	4.____________________
2.____________________	5. ____________________
3. ____________________	6. ____________________

Yuka Shimizu
Child Care Program Director

Bellevue Children's Academy
Child Care Site

14600 NE 24th Street, 14640 NE 24th Street, and/or 14719 NE 29th Place, Bellevue, WA 98007
Child Care Center Address

By signing below, I indicate my approval to release the information requested above to my child's licensed child care program.

____________________ ____________________ __________

Parent/Guardian's Signature Parent/Guardian's Name *(please print)* Date

____

Parent/Guardian's Address

THE HEALTH CARE PROVIDER'S ALLERGY/INTOLERANCE REPORT (Continued)

Name of Child:____Birth Date:_____________

Food Allergy *(please print)* **List each food separately:**	**Please Circle the Medical Condition:**			**Please List Appropriate Substitute Food(s):**
	Food Intolerance: Food Allergy:	Yes Yes	No No	
	Food Intolerance: Food Allergy:	Yes Yes	No No	
	Food Intolerance: Food Allergy:	Yes Yes	No No	
	Food Intolerance: Food Allergy:	Yes Yes	No No	

Other Allergy *(please print)* **List each item separately:**	**Please Circle the Reaction:**			**Plan for Management:**
	Mild: Severe: Mild: Severe:	Yes Yes Yes Yes	No No No No	

*** For an Allergy, please complete the CHILD CARE EMERGENCY PLAN FOR ALLERGIC REACTIONS, below.**

Health Care Provider's Name *(please print)*: ____

Health Care Provider's Signature ***(Required)***:_________________________________Date:____________

Mailing Address of Health Care Provider: ____

____

Phone of Health Care Provider:____

Please return to the child care program at the address listed below:

Bellevue Children's Academy, 14600 NE 24th Street, Bellevue, WA 98007

Bellevue Children's Academy
Allergy/Intolerance Report *and* Emergency Plan for Allergic Reaction Form

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 change quickly. 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, below.
- 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's Name *(please print)*: ____

Health Care Provider's Signature ***(Required)***:_________________________________ Date: _______________

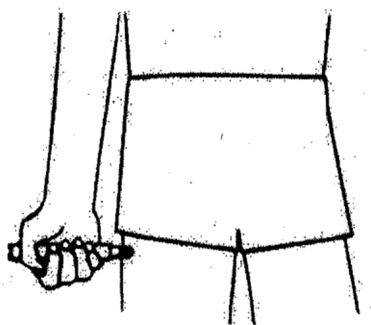
CHILD CARE EMERGENCY PLAN FOR ALLERGIC REACTIONS (Continued)

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 gray activation cap.**

2. **Hold black 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 with the child. Massage the injection area for 20 seconds.**