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

Public Health
Seattle & King County

Food Intolerance Care Plan Request Form

Child's name: _____

Child's date of birth: _____

Early Learning or Child Care Program Director: Michael Gwaltney

Early Learning or Child Care Program: Bellevue Children's Academy

Mailing Address: 14600 NE 24th St., Bellevue WA 98007

Phone Number: 425-649-0791

Fax Number: _____

Healthcare Provider: The child listed above attends our program. This packet includes forms to help meet our licensing standards for medications and individual care plans. **Please complete pages 2-3.** These are forms that require a healthcare provider's instructions and signature.

If the child has a diagnosed food allergy, please contact the program listed above to request the Allergy 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: _____

This page to be completed by:
Healthcare Provider

Public Health
Seattle & King County

Food Intolerance Care Plan

Child's name: _____

Child's date of birth: _____

Healthcare Provider: The WAC requires written instructions from a licensed healthcare provider for any child with a known special dietary requirement due to a health condition. **Please fill out the following information, including symptoms, appropriate food substitutions, and emergency response plans.**

Food Intolerance (List each food separately)	**Symptoms of Intolerance**	**Appropriate Food Substitutions**

Emergency Response Plan

Call parent or guardian if the following symptoms are present:
Call 911 Emergency Medical Services (EMS) and emergency contacts if the following symptoms are present:
Steps to take while waiting for EMS to arrive:
Additional healthcare provider notes:

This page to be completed by:
Healthcare Provider and Parent or Guardian

Public Health
Seattle & King County

Food Intolerance Care Plan (Continued)

By signing below, I attest the child above does not have a diagnosed allergy to the food(s) listed on page 2.

Healthcare Provider Name (Printed): _____

Healthcare Provider Signature: _____

Healthcare Provider Phone Number: _____

Date: _____

Parent or Guardian: The WAC requires written and signed consent from a child's parent or guardian before a program follow a care plan that is completed by a licensed healthcare provider.

By signing below, I give the program permission to follow this care plan as ordered by the licensed healthcare provider. **I confirm that the foods listed on this care plan are not related to a diagnosed food allergy.**

Parent or Guardian Name (Printed): _____

Parent or Guardian Signature: _____

Date: _____

This page to be completed by:
Parent or Guardian

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: _____