Food Allergy/Intolerance Care Plan

This **Food Allergy/Intolerance Care Plan** is a general guideline to facilitate safety in a child care or early learning setting. It is up to the health care provider to ensure that this form is complete and addresses the child's specific needs for managing an allergy or intolerance while participating in a child care program. This document contains personal health information and should be kept confidential. Thank you for your attention to this matter.

If medication is required please complete the Allergy and Anaphylaxis Emergency Plan (American Academy of Pediatrics, 2017.)

List each food separately	Describe how the child reacts to the food	List appropriate food substitutes
	Severe or potentially severe reaction: Yes* ☐ No ☐	
	Severe or potentially severe reaction: Yes* ☐ No ☐	
	Severe or potentially severe reaction: Yes* ☐ No ☐	

Please add any additional information or comments as needed.

____

____

Other medical professionals working with the child list below: *(e.g., medical provider, food allergy specialist, registered dietician,)*

Name	*Title*	*Contact Info*	*Consent for Sharing Info*

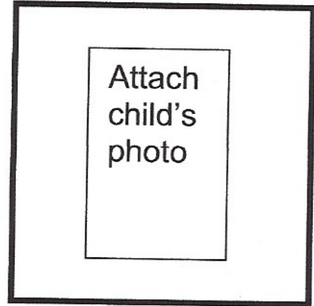
Signature

Parent/Guardian	Phone	Date
Child Care Facility Director	Phone	Date
Health Care Provider Name:	Phone	Date
Health Care Provider Signature:		

CCHOP: 4/22/2018_KL
This form was developed from Caring For Our Children, National Health and Safety Performance Standards, Guidelines for Ealry Care and Education Programs, 3rd ed. Standard 3.5.0.1,

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 ____

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. Inject 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 symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type):__________________ Dose: ☐ 0.15 mg ☐ 0.30 mg (weight more than 25 kg)
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**

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Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
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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: (___) _____-_________

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Medication Authorization

Attach picture of child here.

See back of form for medication log

Dear Parents: Please make sure you have reviewed and signed our medication policy.

Child's Name: *First* *Last*	Weight:	Date of birth:

MEDICATION INFORMATION

Medication:	When to give:
Route: *(e.g., by mouth)*	Dose:
Reason for medication:	Medication expiration date:
	Allergies:
Start date: Stop date:	Storage Requirements: Refrigeration: ☐ YES ☐ NO
Special Instructions: *(e.g., take with food)*	Possible side effects:
Notes:	Medication last given?

PARENT PERMISSION TO GIVE MEDICATION

- I hereby give permission for the child care staff to administer medication as prescribed above.
- I also give permission for the caregiver/teacher to contact the prescribing health professional about the administration of this medication.
- I have administered at least one dose of medication to my child without adverse effects, except one-time emergency medications *(e.g. Epi Pen)*.

Parent/Guardian Signature: Phone:

Print Name: Alternate Phone:

MEDICAL PROVIDER'S INFORMATION

Name: Phone:

Signature:

Prescription label has medical provider's complete information and name ☐ YES ☐ NO

OFFICE USE ONLY

Storage location: Locked ☐ YES ☐ NO	Name of staff receiving medication:
Individual Health Care Plan up-to-date? ☐ YES ☐ NO ☐ Not required for this medication	Amount of medicine received:
Emergency Information up-to-date? ☐ YES ☐ NO	Date:

Attach picture of child here.

Medication Record

See back of form for medication authorization.

Child's Name: *First* *Last*	Medication:

Compare Medication Authorization to container label *at each administration.*
Check 5 Rights: ✓ **CHILD** ✓ **MEDICATION** ✓ **DOSE** ✓ **ROUTE** ✓ **TIME** **and** ✓ **LAST GIVEN?**

DATE	TIME	MEDICATION	DOSAGE	NOTES: Incidents, Reason not given	STAFF

Error Form Completed ☐ YES ☐ NO *(see child's file)*

TO BE COMPLETED BY CHILD CARE PROVIDER:

I am trained to give this medication and understand the child care medication policy and procedures.

Print Name________________________ **Print Name**________________________

________________________ (______) ________________________ (______)
Signature **(initials)** **Signature** **(initials)**

Medication Returned: Date:

Parent/guardian Signature: Staff signature:

If you can't return the medication, contact Take Back Your Meds at 1-800-732-9253 for proper disposal and location.
Do not put in trash or toilet!

Disposal Location: Signature: Date:

SNOHOMISH HEALTH DISTRICT
WWW.SNOHD.ORG

Diaper Cream/Ointment Authorization Form

Child Care Facility Name:

Parent/Guardian permission is required for all diaper cream or diaper ointment application. The child care follows these guidelines regarding diaper cream and diaper ointment:

1. Acceptable diaper creams/ointments will be in compliance with **WAC 170-295-3060**; will be over the counter or prescription only, and will list the active ingredients. Diaper creams and ointments are considered a medication. Homemade or herbal remedies are not accepted.
2. Diaper cream/ointment will only be applied to the area listed below.
3. Diaper cream/ointment will be provided by ☐ parents ☐ child care
4. If diaper cream/ointment is provided by parents, please label with child's first and last name.

Please provide the following information:

Child's Name:	
Date of Birth:	
Name of Diaper Cream/Ointment:	
Reason for Diaper Cream/Ointment:	
Where to Apply:	How Frequently to Apply:
Active Ingredient(s):	
Medication Start Date:	Medication Stop Date:
Authorization Form Filled Out on:	Authorization Expires: (6 months from start.)
Comments or specific information (such as possible side effects, areas to avoid when applying diaper cream, etc):	

I authorize the use of the above diaper cream/ointment on my child. I understand that this cream will be applied to my child as indicated on this form.

Parent/Guardian Signature:	Date:
Daytime Phone Number:	

See back of form

Child Care Health Outreach Program
3020 Rucker Avenue ■ Everett, WA 98201-3900 ■ www.snohd.org ■ tel: 425.252.5415

Diaper Cream/Ointment Application Record

Child's Name:

Name of Diaper Cream/Ointment to Be Used:

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

List any notes or side effects below. Notify parent/guardian immediately.

Signatures (and initials) of staff applying diaper cream:

____________________ (   )   ____________________ (   )

____________________ (   )   ____________________ (   )

____________________ (   )   ____________________ (   )

Child Care Health Outreach Program
3020 Rucker Avenue ■ Everett, WA 98201-3900 ■ www.snohd.org ■ tel: 425.252.5415

SNOHOMISH HEALTH DISTRICT
WWW.SNOHD.ORG

Sunscreen Authorization Form

Child Care Facility Name:

Parent/Guardian permission is required for all sunscreen application. Sunscreen products are applied to provide protection from the sun's UV rays. The child care follows these guidelines regarding sunscreen:

1. Acceptable sunscreens will be broad-spectrum with an SPF of 30 or higher.
2. Sunscreen will be applied 20-30 minutes before going outside, especially during the summer months and between 10 am and 4 pm.
3. Sunscreen will not be applied to children younger than 6 months without a doctor's note.
4. Parents are encouraged to send a hat with a wide brim for their child to wear outside.
5. Sunscreens will be stored at room temperature and out of reach of children.
6. Sunscreen product will be provided by: ☐ parents ☐ child care

Please provide the following information:

Child's Name:	
Date of Birth:	
Name of Sunscreen and SPF:	
Active Ingredient(s):	
Authorization Form Filled Out on:	Authorization Expires: (6 months from start date)
Comments or specific information (such as possible side effects, areas to avoid when applying sunscreen, etc.)	

I authorize the use of the above sunscreen on my child. I understand that this sunscreen will be applied to exposed skin, which may include the face, ears, arms, shoulders, legs, and feet.

Parent/Guardian Signature:	Date:
Daytime Phone Number:	

See back of form

Child Care Health Outreach Program
3020 Rucker Avenue ■ Everett, WA 98201-3900 ■ www.snohd.org ■ tel: 425.252.5415

Sunscreen Application Record

See back of form for authorization.

Child's Name:

Name of Sunscreen and SPF:

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

List any notes or side effects below. Notify parent/guardian immediately.

Signatures (and initials) of staff applying sunscreen:

____________________ (   ) ____________________ (   )

____________________ (   ) ____________________ (   )

Child Care Health Outreach Program
3020 Rucker Avenue ■ Everett, WA 98201-3900 ■ www.snohd.org ■ tel: 425.252.5415

ASTHMA ACTION PLAN

Asthma and Allergy Foundation of America
aafa.org

Name:	Date:
Doctor:	Medical Record #:
Doctor's Phone #: Day	Night/Weekend
Emergency Contact:	
Doctor's Signature:	

The colors of a traffic light will help you use your asthma medicines.

GREEN means Go Zone! Use preventive medicine.

YELLOW means Caution Zone! Add quick-relief medicine.

RED means Danger Zone! Get help from a doctor.

Personal Best Peak Flow: ____________

GO

Use these daily controller medicines:

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work & play

Peak flow: from ______ to ______

MEDICINE	HOW MUCH	HOW OFTEN/WHEN
For asthma with exercise, take:		

CAUTION

Continue with green zone medicine and add:

You have *any* of these:
- First signs of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

Peak flow: from ______ to ______

MEDICINE	HOW MUCH	HOW OFTEN/ WHEN

CALL YOUR ASTHMA CARE PROVIDER.

DANGER

Take these medicines and call your doctor now.

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard & fast
- Nose opens wide
- Trouble speaking
- Ribs show (in children)

Peak flow: reading below ______

MEDICINE	HOW MUCH	HOW OFTEN/WHEN

GET HELP FROM A DOCTOR NOW! Your doctor will want to see you right away. It's important! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT.

Make an appointment with your asthma care provider within two days of an ER visit or hospitalization.

SPECIAL CARE PLAN FOR A CHILD WITH BEHAVIOR PROBLEMS

This sheet is intended to be used by health care providers and other professionals to formulate a plan of care for children with severe behavior problems that parents and child care providers can agree upon and follow consistently.

Part A: To be completed by parent/custodian.

Child's name: ______________________ Date of birth: ______________

Parent name(s): ______________________ ______________________

Parent emergency numbers: ____________ ______________________

Child care facility/school name: ______________________ Phone: __________

Health care provider's name: ______________________ Phone: __________

Other specialist's name/title: ______________________ Phone: __________

Part B: To be completed by health care provider, pediatric psychiatrist, child psychologist, or other specialist.

1. Identify/describe behavior problem: ______________________
2. Possible causes/purposes for this type of behavior: (Circle all that apply.)

   medical condition ______________________ *(specify)*

   attention-getting mechanism

   gain access to restricted items/activities

   escape performance of task

   psychiatric disorder ______________________ *(specify)*

   tension release

   developmental disorder

   neurochemical imbalance

   frustration

   poor self-regulation skills

   other: ______________________
3. Accommodations needed by this child: ______________________

   ____
4. List any precipitating factors known to trigger behavior: ______________________

   ____
5. How should caregiver react when behavior begins? (Circle all that apply.)

   ignore behavior

   avoid eye contact/conversation

   request desired behavior

   use helmet*

   physical guidance (including hand-over-hand)

   model behavior

   use diversion/distraction

   use substitution

   use pillow or other device to block self-injurious behavior (SIB)*

   other: ______________________

   ____

*directions for use described by health professional in Part D.

6. List any special equipment this child needs: ____________________

____

7. List any medications this child receives:

Name of medication: ____________ Name of medication: ____________
Dose: ____________ Dose: ____________
When to use: ____________ When to use: ____________
Side effects: ____________ Side effects: ____________

____________ ____________

Special instructions: ____________ Special instructions: ____________

____________ ____________

8. Training staff need to care for this child: ____________________

____

9. List any other instructions for caregivers: ____________________

____

Part C: Signatures

Date to review/update this plan: ____________

Health care provider's signature: ____________________ Date: ________

Other specialist's signature: ____________________ Date: ________

Parent signature(s): ____________________ Date: ________

____________________ Date: ________

Child care/school director: ____________________ Date: ________

Primary caregiver signature: ____________________ Date: ________

Part D: To be completed by health care provider, pediatric psychiatrist, child psychologist, or other specialist.

Directions for use of helmet, pillow, or other behavior protocol: ____________________

____

____

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____

____

S. Bradley, JD, RN, C - PA Chapter American Academy of Pediatrics reviewed by J. Hampel, PhD and R. Zager, MD
Reviewed and reaffirmed 6-2018

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   escape performance of task
   psychiatric disorder ______________________ *(specify)*
   tension release
   developmental disorder
   neurochemical imbalance
   frustration
   poor self-regulation skills
   other: ______________________

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Side effects: ______________________ Side effects: ______________________

______________________ ______________________

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______________________ ______________________

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____

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Other specialist's signature: ______________________________ Date: __________

Parent signature(s): ______________________________ Date: __________

______________________________ Date: __________

Child care/school director: ______________________________ Date: __________

Primary caregiver signature: ______________________________ Date: __________

Part D: To be completed by health care provider, pediatric psychiatrist, child psychologist, or other specialist.

Directions for use of helmet, pillow, or other behavior protocol: ______________________

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____

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____

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