Allergies and Food Intolerance Packet

As a licensed child care program we are required to meet state licensing standards. By completing the following forms this ensures that WSUCC complies with licensing and helps our staff to provide excellent care for your child. WSUCC policy requires that these forms be updated at least annually.

If your child has an allergy or intolerance please complete the following forms:

Allergy/Intolerance Statement:- Please help us to comply and meet the health needs of your child by completing the Allergy/Intolerance Statement form. We need to know which items the child is allergic or intolerant to, the steps to take to treat an allergic reaction, and appropriate substitute foods to assure that the child's nutrition is not compromised. This form must be signed by your Health Care Provider and be updated whenever there is a change in your child's health care plan or at least annually.

Individual Health Plan for Allergic Reactions:- This form will give the WSUCC staff the necessary information to identify symptoms of an allergic reaction in your child and the steps your health care provider would like us to follow. This form must be signed by your Health Care Provider and be updated whenever there is a change in your child's health care plan or at least annually.

Egg and Dairy Allergies

Egg Allergies: Health Care Providers please specify if items containing egg (such as bread) should also be omitted from child's diet.

Dairy/Milk Allergies & Intolerances: Health Care Providers please specify if items containing milk (such as bread) and dairy products (such as cheese and yogurt) should also be omitted from child's diet.

Washington State University Children's Center
1425 Olympia Avenue | Pullman, WA 99164-3454
Phone: 509-335-8847 Fax: 509-335-7980
Email: childrens.center@wsu.edu

Allergy/Intolerance Statement

Name of Child:_____ Birthdate:_____

(Please Print)

Food Allergy **List each food Separately**	**Check the medical condition**	**List appropriate substitute food(s)**	**Signs of a reaction**
	Food Intolerance ☐ Food Allergy* ☐		
	Food Intolerance ☐ Food Allergy* ☐		
	Food Intolerance ☐ Food Allergy* ☐		
	Food Intolerance ☐ Food Allergy* ☐		

*** Please Note: For a Food Allergy, an Individual Health Plan for Allergic Reactions must be completed by a Health Care Provider.**

Non-Food Allergy*

Please list Allergy	**Severity**	**Signs of a Reaction**
	Mild ☐ Severe ☐	
	Mild ☐ Severe ☐	

*** Please Note: For a Non-Food Allergy, an Individual Health Plan for Allergic Reactions must be completed by a Health Care Provider.**

Health Care Provider Name:_____

Health Care Provider Signature:_____ Date:_____

Health Care Provider Phone Number:_____

Please keep WSUCC updated whenever there is a change in your child's health care plan. The Allergy/Intolerance Statement expires after one year.

Please return completed forms to WSUCC by fax: 509-335-7980 or email: childrens.center@wsu.edu

Revision: April 2016

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Individual Health Plan for Minor Allergic Reactions

ALLERGY TO: _____

Child's Name: _____ D.O.B: _____ Weight: _____

SIGNS OF AN ALLERGIC REACTION

1) Antihistamines may be given, if ordered by a health care provider.

2) Stay with the child; alert emergency contacts.

3) Watch closely for changes. If symptoms worsen, give epinephrine, <u>if prescribed</u>.

ACTION FOR <u>MINOR</u> REACTION:

If symptom(s) are: _____

_____

Administer (Medication/dose/route): _____

_____

Then call: Parent/Guardian

Additional Instructions: _____

_____

_____

Parent/guardian name: _____ Phone #: _____

Parent/guardian signature: _____ Date: _____

Health Care Provider name: _____ Phone #: _____

Health Care Provider signature (Required): _____ Date: _____

Trained Staff Member	Phone Number	Room Number

Please keep WSUCC updated whenever there is a change in your child's health care plan. The Individual Health Plan for Allergic Reactions expires after one year.

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Individual Health Plan for Severe Allergies

Name of Child:_____ Birthdate:_____

Allergy to:_____

Weight:_____ Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ No

Non-Food Allergy*

Please list Allergy	**Signs of a Reaction**

*** Please Note: For a Non-Food Allergy, an Individual Health Plan for Allergic Reactions must be completed by a Health Care Provider.**

Food Allergy*

Please list Food Allergy	**Signs of a Reaction**

*** Please Note: For a Food Allergy, an Individual Health Plan for Allergic Reactions must be completed by a Health Care Provider.**

Health Care Provider Name:_____

Health Care Provider Signature:_____ Date:_____

Health Care Provider Phone Number:_____

Please keep WSUCC updated whenever there is a change in your child's health care plan. The Individual Health Plan for Severe Allergies expires after one year.

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Extremely reactive to the following foods:_____

_____

Therefore:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

☐ If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

For any of the following **SEVERE SYMPTOMS:**

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

Mild Symptoms:

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

For **Mild Symptoms** from **more than one** system area, give epinephrine.

Medications/Doses

Epinephrine Brand:_____ Dose:_____

Antihistamine Brand/Generic:_____ Dose:_____

Other (e.g., inhaler-bronchodilator if wheezing):_____

Parent/guardian name:_____ Phone #:_____

Parent/guardian signature:_____ Date:_____

Health Care Provider name:_____ Phone #:_____

Health Care Provider signature (Required):_____ Date:_____

Please keep WSUCC updated whenever there is a change in your child's health care plan. The Individual Health Plan for Severe Allergic Reactions expires after one year.

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