Date: _____

To Whom It May Concern:

_____is a child enrolled in our child care program. We have been advised that he/she is allergic or intolerant to the following substances:

_____
_____
_____
_____

As a licensed child care program we are required to meet state licensing standards. Please help us to comply and meet the health needs of your patient by completing the Allergy/Intolerance Statement form and, if necessary, Emergency Care Plan for Allergic Reactions. We need to know which allergens cause a reaction in the child, method(s) of contact, steps to take to treat an allergic reaction, and appropriate substitutes so that the child's care/nutrition is not compromised.

Thank you for your help in this important health matter.

Sincerely,

Director
University District Children's Center
5031 University Way NE
Seattle, WA 98105

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)

_____
_____
Parent/Guardian's Address

Child's Name:_______________________________ **Date of Birth:**___________________

*Please list each allergy/intolerance separately. For all allergies, please fill out the **Emergency Care Plan for Allergic Reactions**.*

Allergen: ___________________________________ ☐ Allergy ☐ Intolerance
Appropriate Substitutes: ____

Allergen: ___________________________________ ☐ Allergy ☐ Intolerance
Appropriate Substitutes: ____

Allergen: ___________________________________ ☐ Allergy ☐ Intolerance
Appropriate Substitutes: ____

Allergen: ___________________________________ ☐ Allergy ☐ Intolerance
Appropriate Substitutes: ____

Allergen: ___________________________________ ☐ Allergy ☐ Intolerance
Appropriate Substitutes: ____

Allergen: ___________________________________ ☐ Allergy ☐ Intolerance
Appropriate Substitutes: ____

Allergen: ___________________________________ ☐ Allergy ☐ Intolerance
Appropriate Substitutes: ____

Allergen: ___________________________________ ☐ Allergy ☐ Intolerance
Appropriate Substitutes: ____

______________________________________ ______________________________________
Health Care Practitioner's Signature Date

______________________________________ ______________________________________
Practitioner's Name (Please print) Practitioner's Phone Number

____
____
Practitioner's Mailing Address

Please return to:
University District Children's Center
5031 University Way NE
Seattle, WA 98105
(206) 632-5189

EMERGENCY CARE PLAN FOR ALLERGIC REACTIONS

Child's Name:_____ **Date of Birth:**_____

Allergen:_____ **Asthma?** ☐ Yes ☐ No

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 quickly change. All the above symptoms can potentially progress to a life-threatening situation.

Actions for a minor reaction:

- If symptoms are: _____
- Administer (medication, dose, route): _____
  _____
- Call parents/guardians
- Call Health Care Practitioner
- Take additional steps outlined by practitioner: _____
  _____
  _____
- If symptoms do not improve within 10 minutes, follow ***Actions for Severe Reaction*** as outlined below:

Actions for a severe reaction:

- If symptoms are: _____
- Administer (medication, dose, route) IMMEDIATELY: _____
  _____
- **CALL 911 – never hesitate to call 911!**
- Call parents/guardians
- Call Health Care Practitioner
- Take additional steps outlined by practitioner: _____
  _____
  _____

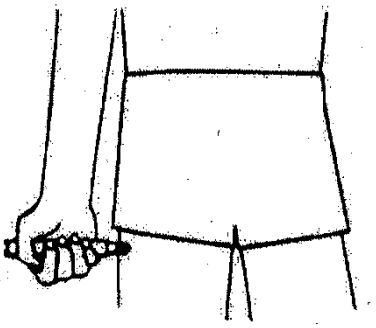
_____ _____
Parent/Guardian's Signature Date

_____ _____
Health Care Practitioner's Signature Date

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. Hold in place and count to 10. The EpiPen unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 20 seconds.