

## **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:**- Please fill out the appropriate form for either a minor or severe reaction, both forms are included in this packet. 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.

**Medication Authorization:**-If your child may require medication during an allergic reaction or the use of an EpiPen, please have your Health Care Provider fill out the appropriate sections included on the individual health plan authorizing those medications. Please make sure to check expiration dates on medications periodically and replace as necessary. A medication log will be kept with your child's records.



## 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.*

# Individual Health Plan for Minor Allergic Reactions

**ALLERGY TO:** \_\_\_\_\_

Child's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Weight: \_\_\_\_\_

## SIGNS OF AN ALLERGIC REACTION



**NOSE**

Itchy/runny  
nose,  
sneezing



**MOUTH**

Itchy mouth



**SKIN**

A few hives,  
mild itch



**GUT**

Mild nausea/  
discomfort

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, if prescribed.**

## ACTION FOR MINOR 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.*

# 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.*

**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.*

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

### EPIPEN and EPIPEN JR Directions

Trained Staff Members		
Name	Room Number	Phone Number (Classroom #)

Emergency Contacts		
Name	Relation	Phone Number

**Remove from carrying case (Keep hand away from orange tip)**



**If needed, assist the child to perform the following instructions:**

**1** Form fist around EpiPen® and **PULL OFF BLUE SAFETY CAP.**



**2 POSITION ORANGE END** about 10cm away from outer mid-thigh\*.  
\* Either clothed, or unclothed, avoiding seams and pocket areas.



**3 SWING AND JAB ORANGE TIP** into thigh at 90° angle and hold in place for 10 seconds.



**4 REMOVE EpiPen®** Massage injection site for 10 seconds\*.  
\*After use the orange needle cover automatically extends to cover the injection needle.



**5. IF NOT DONE ALREADY-CALL 911**