The Rainbow School

Health Care Provider's Allergy/Intolerance Report

Name Of Child _____ Today's Date _____

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

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

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 the Child Care Emergency Plan for Allergic Reactions. 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.

Thank you for your help in this important health matter.
Sincerely,

Mary L. Fraser — The Rainbow School
Child Care Program Director — Child Care Site

25620 SE 39th Way, Issaquah, WA 98029-7792
Child Care Center Address

By signing below, I indicate my approval to release the information requested above to my child's licensed child care program.

_____ _____ _____
Parent/Guardian Signature — Date — Parent/Guardian Name (print)

Parent/Guardian Address _____

_____

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Allergy/Intolerance Statement

Name of Child _____Birthdate_____

(Please print)

Food Allergy: List each food separately	**Check the medical condition**	**List appropriate substitute food(s)**
	Food Intolerance ☐ Yes ☐ No Food Allergy ☐ *Yes ☐ No	
	Food Intolerance ☐ Yes ☐ No Food Allergy ☐ *Yes ☐ No	
	Food Intolerance ☐ Yes ☐ No Food Allergy ☐ *Yes ☐ No	
	Food Intolerance ☐ Yes ☐ No Food Allergy ☐ *Yes ☐ No	

Other Allergy: Please list items:	**Reaction:**	**Plan for management:**
	Mild ☐ Yes ☐ No Severe ☐ Yes ☐ No	

*** For an Allergy, please complete the Child Care Emergency Plan for Allergic Reactions.**

Health Care Provider Name _____

Health Care Provider Signature_____Date_____

Mailing Address (Print) Phone _____

_____

_____

Please return to the child care program at the address listed below:

_____

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Child Care Emergency Plan for Allergic Reactions

ALLERGY TO: _____

Student's Name:_____D.O.B:_____

Asthma Yes* ☐ No ☐ *High Risk for severe reaction

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.

Action for *minor* reaction:

If symptom(s) are:_____

☐ **Administer:**_____
medication/dose/route

☐ **Then call: Parent/Guardian and Health Care Provider**

☐ **If condition does not improve within 10 minutes, follow steps for Severe Reaction below:**

Action for *severe* reaction:

If symptom(s) are:_____

☐ **Administer:**_____**IMMEDIATELY**!
medication/dose/route

☐ **Call: 911 (Never hesitate to call 911)**

☐ **Call: Parent or Guardian**

☐ **Call: Health Care Provider**

Parent/guardian name_____ phone # _____

Parent/guardian signature_____ Date: _____

Health Care Provider name_____

Health Care Provider signature (Required) _____

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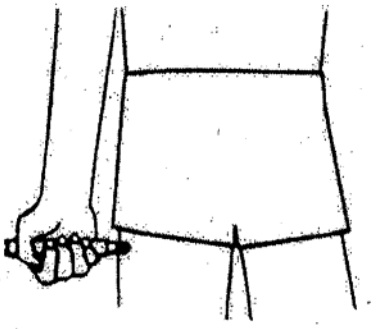
Emergency Contacts	Trained Staff Members
1. _____	1._____Room_____
Relation:_____Phone_____	2._____Room_____
2. _____	3._____Room_____
Relation:_____Phone_____	
3. _____	
Relation:_____Phone_____	

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

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The Rainbow School Instructions for Medications

Student _____ Today's Date _____

State licensing requirements permit child care facilities to administer medications to children under the following circumstances:

- Medications shall be dispersed only on the written approval of a parent or guardian.
- Medications shall be dispersed only as specified on the prescription bottle or as otherwise authorized by a physician.
- Medications must be stored in their original container. The container shall contain the Patient's name, date of purchase, and dosage.
- Over-the-counter medications may only be disbursed with specific written consent of your child's attending physician.
- Medications (over-the-counter and prescription) will be returned to the parent or guardian at the end of each week. If the same medication is required during the following week, a new Instructions for Medications form will need to be filled out.

Please fill out a "Today Only" form to indicate to your child's teachers that your child will be taking medication today.

Please provide the following information:

Child's Name: _____ Date of Birth/Age: _____

Reason for Medication: _____

Medication Name: _____ Amount to be given: _____

Start Date: _____ Stop Date: _____

Time to be given (can NOT be given "as needed"): _____

Possible Side Effects: _____

☐ Above information consistent with label? ☐ Oral ☐ Topical ☐ Other Requires Refrigeration: ☐ yes ☐ no

Special Instructions: _____

_____

I authorize the staff of The Rainbow Staff to administer the above medication as directed above.

_____
Parent Signature

Medication Record

(Must be filled out by the person who gives the medication)

Date	Time	Dosage	Initials	Reason NOT Given	Side Effects Observed

Original - With Medication
Copy - Teacher