the CDC of Circle C Ranch

SEVERE ALLERGIES/MEDICAL CONDITIONS FORM

(Do not complete this form if your child does not have an allergy or medical condition)

PART I (to be completed by a Licensed Health Care Provider)

Date: _____

Dear Health Care Provider,

Your Patient, _____ is enrolled in The Child Development Center. Please provide emergency care for the prevention of anaphylaxis in the event the child comes into contact with a certain allergen(s), as described below and/ or also indicate any medical conditions that would require treatment. Please complete Part I of this instruction record. This record will remain in the child's file at The Child Development Center so we may assist with the allergy care and needs of the child. If you need to provide further instructions or clarifications, please use a separate sheet of paper, which will become a part of this record and will be kept with this form in the child's file at The Child Development Center.

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

KNOWN ALLERGENS/MEDICAL CONDITION: (Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction (i.e. Anaphylactic shock) in the child.)

☐ Bee Sting ☐ Other Insect Bite(s): (identify):_____

☐ Asthma ☐ Seizure Disorders

☐ Food Allergy: (identify all foods or groups of foods that must be avoided):

_____

_____

☐ Other: (identify): _____

SYMPTOMS: (Please provide a complete list of all symptoms that indicate the child has come into contact with an allergen and requires emergency treatment.)

☐ Hives ☐ Vomiting ☐ Shortness of Breath ☐ Swelling of the Face or Lips

☐ Diarrhea ☐ High Fever ☐ Loss of consciousness

☐ Other: (explain): _____

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PROCEDURES: (Please number the following steps in the order in which they should be taken. Example: 1. Administer the following medication, 2. Call parents, 3. Administer EPI-PEN

_____ Administer the following Medication: (provide name, dosage, and method of Administration):

_____

_____

_____ Administer EPI-PEN: (provide instructions for administration)

_____ Call Emergency Medical Services (911)

_____ Call the child's parent or guardian

_____ DO NOT administer medication in the absence of KNOWN exposure to allergen

_____ Other (explain): _____

RECREATIONAL ACTIVITIES:

1. The child may participate in recreational activities. ☐ Yes ☐ No

2. Recreational Activity Restrictions: ☐ None ☐ Some restrictions (explain recreational activity restrictions):

_____

_____

HEALTH CARE PROVIDER INFORMATION:

Office: _____

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Signature: _____ Date: _____

PART II: (to be completed by the child's Parent(s) and/ or Legal Guardian)

By signing this form, I/We authorize The Child Development Center to follow the instructions contained in this Authorization for Emergency Care of Children with Severe Allergies/Medical Conditions Form. I/We agree to update this form **every twelve (12) months** or sooner if my/our child's needs change.

PARENT(S)/ LEGAL GAURDIAN(S):

Name: _____ Relationship: _____

Address: _____

Phone #: _____ Cell Phone #: _____

Emergency Contact #: _____

Signature: _____ Date: _____

Name: _____ Relationship: _____

Address: _____

Phone #: _____ Cell Phone #: _____

Emergency Contact #: _____

Signature: _____ Date: _____

For Office Use Only

This completed Authorization for Emergency Care for Children with Severe Allergies/Medical Conditions Form was received by The Child Development on (date) _____. This Form must be updated by (date) _____.

Received By: (Print Name) _____

Signature: _____

Title: _____