



## **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 Circle C 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 Circle C 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 Circle C 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): \_\_\_\_\_

**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 #: \_\_\_\_\_

*\*Parent's full name as electronic signature*

Signature: \_\_\_\_\_

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

Date: \_\_\_\_\_

By signing this form, I/We authorize Circle C 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 Circle C Child Development on (date) \_\_\_\_\_. This Form must be updated by (date) \_\_\_\_\_.

Received By: (Print Name) \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_