



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 #: _____

Signature: _____

Date: _____

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

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: _____

**Parent's/Legal Guardian full name as electronic signature*

Name: _____ Relationship: _____

Address: _____

Phone #: _____ Cell Phone #: _____

Emergency Contact #: _____

Signature: _____ Date: _____

**Parent's/Legal Guardian full name as electronic signature*

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: _____