

Food Intolerance Care Plan Request Form

Child's Name: _____

Child's Date of Birth: _____

Early Learning or Child Care Program Director: Abby Maclean

Bellevue Children's Academy

Early Learning or Child Care Program: EARLY CHILDHOOD EDUCATION

Mailing Address: Bellevue Children's Academy, North Campus - Satellite 1, 14719 NE 29th Pl., Bellevue, WA 98007
Bellevue Children's Academy, North Campus - Satellite 2, 14673 NE 29th Pl., Bellevue, WA 98007

Phone Number: 425-649-0791 - Satellite 1 (Opt. 3); Satellite 2 (Opt. 4)

E-mail: satellite@bcacademy.com

Healthcare Provider: The child listed above attends our program. This packet includes forms to help meet our licensing standards for medications and individual care plans. **Please complete pages 2-3.** These are forms that require a healthcare provider's instructions and signature.

If the child has a diagnosed food allergy, please contact the program listed above to request the Allergy Care Plan Packet.

By signing below, I give permission to my child's healthcare provider to release the health information requested in the following care plan to my child's program.

Parent or Guardian Name (Printed): _____

Parent or Guardian Signature: _____

Date: _____

Parent or Guardian Phone Number: _____



Food Intolerance Care Plan

Child's name: _____

Child's date of birth: _____

Healthcare Provider: The WAC requires written instructions from a licensed healthcare provider for any child with a known special dietary requirement due to a health condition. **Please fill out the following information, including symptoms, appropriate food substitutions, and emergency response plans.**

Food Intolerance (List each food separately)	Symptoms of Intolerance	Appropriate Food Substitutions

Emergency Response Plan

Call parent or guardian if the following symptoms are present:

Call 911 Emergency Medical Services (EMS) and emergency contacts if the following symptoms are present:

Steps to take while waiting for EMS to arrive:

Additional healthcare provider notes:



Food Intolerance Care Plan (Continued)

By signing below, I attest the child above does not have a diagnosed allergy to the food(s) listed on page 2.

Healthcare Provider Name (Printed): _____

Healthcare Provider Signature: _____

Healthcare Provider Phone Number: _____

Date: _____

Parent or Guardian: The WAC requires written and signed consent from a child's parent or guardian before a program follow a care plan that is completed by a licensed healthcare provider.

By signing below, I give the program permission to follow this care plan as ordered by the licensed healthcare provider. **I confirm that the foods listed on this care plan are not related to a diagnosed food allergy.**

Parent or Guardian Name (Printed): _____

Parent or Guardian Signature: _____

Date: _____



Emergency Contact Information

Child's Name: _____

Parent or Guardian: If your child has a medical emergency, program staff need to be able to contact you or another emergency contact as quickly as possible. Please complete the following:

Emergency Contact #1

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #2

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #3

Name: _____

Relationship to Child: _____

Phone Number: _____

