Bellevue Children's Academy & Willows Preparatory School

Allergy/Intolerance Report *and* Emergency Plan for Allergic Reaction Form

2021-2022

THE HEALTH CARE PROVIDER'S ALLERGY/INTOLERANCE REPORT

_____ _____

Student's Name (*please print*) Date

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

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

Program Director	Child Care/School Age Site	Address
Robert Dougherty	BCA Satellite Pre-Prep	14719 NE 29th Pl., Bellevue WA 98007 12280 Woodinville-Redmond Rd. NE, Redmond WA 98052
Britt Dougherty	BCA1 BCA2	14600 NE 24th St., Bellevue WA 98007 14640 NE 24th St., Bellevue WA 98007
Matthew Lippart	WPS	12280 Woodinville-Redmond Rd. NE, Redmond WA 98052

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

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Name (*please print*) Date

_____

Parent/Guardian

THE HEALTH CARE PROVIDER'S ALLERGY/INTOLERANCE REPORT (*continued*)

Name of Child _____ Date of Birth _____

Food Allergy *(please print)* **List each food separately:**	**Please Circle the Medical Condition:**			**Please 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 print)* **List each item separately:**	**Please Circle the Reaction:**			**Plan for Management:**
	Mild:	Yes	No	
	Severe:	Yes	No	
	Mild:	Yes	No	
	Severe:	Yes	No	

***For an Allergy, please complete the CHILD CARE EMERGENCY PLAN FOR ALLERGIC REACTIONS, below.**

Health Care Provider's Name (*please print*): _____

Health Care Provider's Signature (***Required***): _____ Date: _____

Mailing Address of Health Care Provider: _____

(address continued): _____ Phone of Health Care Provider: _____

Please return to the child care program at the address listed below:
Bellevue Children's Academy, 14640 NE 24th Street, Bellevue, WA 98007

A multi-campus IB World School

Bellevue Children's Academy & Willows Preparatory School

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2021-2022

CHILD CARE EMERGENCY PLAN FOR ALLERGIC REACTIONS

ALLERGY TO: _____

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

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

☐ Special situation: If this box is checked, child has an extremely severe allergic reaction to an insect sting or the following food(s): _____. Even if child has MILD symptoms, give **epinephrine.**

SIGNS OF AN ALLERGIC REACTION:

Mild (monitor closely):
- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Severe (immediately administer *epinephrine*):
- Shortness of breath, wheezing, coughing
- Generalized hives/redness all over body
- Vomiting or diarrhea (if severe/combined with other symptoms)
- Tight or hoarse throat, trouble breathing or swallowing
- Swelling of lips or tongue
- Confusion, altered consciousness

Action for *mild* reaction:

If symptom(s) are: _____

- **Administer:** _____ _____ _____
  (*medication)* **(*dose)*** **(*route*)**
- Then call: Parent/Guardian and Health Care Provider, below.
- The severity of symptoms can change quickly. Monitor child closely.

Action for *severe* reaction:

If symptom(s) are: _____

- **Administer:** _____ _____ _____ **IMMEDIATELY!**
  (*medication)* **(*dose)*** **(*route*)**
- **Call: 911 (Must be called WHENEVER epinephrine is administered)**
- **Call: Parent or Guardian**
- **Call: Health Care Provider**
- **Repeat dose of medication? Yes ☐ No ☐ IF YES, when** _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

Health Care Provider's Name (*please print*): _____

Health Care Provider's Signature (***Required***): _____ Date: _____

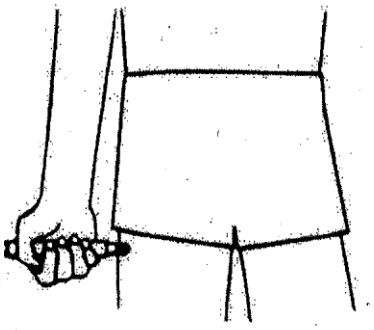
CHILD CARE EMERGENCY PLAN FOR ALLERGIC REACTIONS (*continued*)

Emergency Contacts	Trained Staff Members
1. _____	1. _____
Relation: _____	Room: _____
Phone: _____	2. _____
2. _____	Room: _____
Relation: _____	3. _____
Phone: _____	Room: _____
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 in place and count to 10</u>. The EpiPen unit should then be removed and taken with you to the Emergency Room with the child. Massage the injection area for 20 seconds.**