Child Health Plan and Provider Orders - Dietary Accommodations - Food Allergies/Intolerances

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Center:______________________________ ☐ Early Head Start ☐ Head Start ☐ ECEAP

Child's Name: ______________________________ DOB: ________________ Gender: M / F

Parent/Guardian: ____________________________ Phone: (H) ______________ (C) ______________

My child is allergic or has an intolerance to (list all foods/ingredients):

1. ________________ ☐Allergy ☐Intolerance 3. ________________ ☐Allergy ☐Intolerance
2. ________________ ☐Allergy ☐Intolerance 4. ________________ ☐Allergy ☐Intolerance

Which of the following symptoms occur after exposure?

☐ Hives ☐ Rash ☐ Itching ☐ Swelling ☐ Redness ☐ Tingling ☐ Nausea

☐ Vomiting ☐ Diarrhea ☐ Stomach pain ☐ Gas ☐ Bloating ☐ Other: ____________

Give detailed description:____

What can we do to prevent the symptoms at school/child care?________________________________

____

If your child is exposed to, or eats a food/ingredient that must be avoided, staff should:

☐ Call parent ☐ Send note home with child ☐ Call 911 immediately if Potentially Life-Threatening

Call 911, then call parent/guardian for any of the following symptoms:

- **Mouth:** itching, tingling or swelling of the lips, tongue or mouth
- **Throat:** swelling, sense of tightness in the throat, hoarseness, a hacking cough, trouble swallowing or talking
- **Skin:** very warm or cold to the touch, pale, blue or gray, sweating
- **Gut:** nausea, stomach ache/abdominal cramps, vomiting, and/or diarrhea more than twice
- **Lungs:** difficulty breathing, shortness of breath, repetitive coughing, and/or wheezing
- **Heart:** racing and/or weak pulse, dizziness, fainting or unconsciousness, complaints of chest pain
- **Other:** feelings of anxiety or fear, sudden fatigue, chills, headache, and/or confusion after giving medication

Anaphalaxis Action Plan

- **IF PRESCRIBED BY A PROVIDER, ADMINISTER EPINEPHRINE AS ORDERED** (Epi-pen Jr., Auvi-Q, Twinject)
- **CALL 911 IMMEDIATELY!** 911 must be called **WHENEVER** an **EPINEPHRINE AUTO-INJECTOR** is administered
- **A CPR-TRAINED ADULT** must remain with child at the location where symptoms began until EMS arrives
- **DO NOT HESITATE** to administer **EPINEPHRINE** or call 911 even if the parents cannot be reached
- Advise 911 that child is having a severe allergic reaction and the Epinephrine is being administered
- A CPR trained adult must stay with child at all times, monitor services, and begin CPR if necessary
- Call School Nurse or Health Office per your school district policy
- Give used **EPINEPHRINE AUTO-INJECTOR to EMS** along with a copy of the *Child Health Plan.*

Is medication(s) taken at home? ☐Yes ☐No (list): ____________________

Is medication(s) needed while at school? ☐Yes ☐No (If YES, refer to provider order's)

Is medication(s) needed during transport to/from school? ☐Yes ☐No

Child's Name: ______________________________ DOB: ________________ Gender: M / F

☐No medication is required at school (Please sign below if you agree with this CHP).

Health Care Provider Orders for Medication at School

Important notice to provider:
Please ensure this child has a prescription on file with the pharmacy that matches the orders below. **Our policy requires Health Care Provider Orders and medication labels to match exactly.**

1) Medication Name

2) Symptoms for medication use

3) Dose

4) Frequency & Length of time between doses

5) Route

6) Possible side effects of medication

7) Special administration and/or storage instructions

8) If PRN specify Start date: ____________ **AND** End date: ______________

Health Care Provider's Signature | Date

Print name | Phone # | Fax #

Parent/Guardian Signature | Date

Interpreter Signature | Date

Nurse Consultant Signature | Date

ITE/Teacher | Date | ITP/Assistant | Date | FA/FE/FSS/HV | Date | Dir/C Coor | Date

To be completed by the Health Care Provider:

Child's Name: ______________________________ DOB: ________________ Gender: M / F

Condition: Complete one statement for each condition

☐ **Food Intolerance:** ☐ Milk only ☐ Dairy ☐ Other:____________________

☐ **Food Allergy:** ☐ Dairy ☐ Eggs ☐ Cooked ☐ Cooked in product (i.e. in baked goods) ☐ Soy ☐ Wheat ☐ Fish ☐ Shellfish

☐ Tree Nuts ☐ Peanuts ☐ Other:____________________

Allergy Type: ☐ Ingestion ☐ Environmental ☐ Skin contact

☐ **Medical condition requiring special diet**:____________________

Describe Reaction: ☐ Anaphylaxis ☐ Asthma ☐ Shortness of breath ☐ Rash/Hives
☐ Vomiting ☐ Diarrhea ☐ Other:____________________

Federal law and USDA regulation require nutrition programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, which can include allergies and digestive conditions, but does not include personal diet preferences.

Bodily Functions: ☐Digestive ☐Bowel ☐Bladder ☐Immune System ☐Respiratory ☐Brain ☐Cardiovascular ☐Endocrine ☐Neurological ☐Circulatory ☐Reproductive ☐Normal Cell Growth

Major Life Activities Affected:____________________ (Ex. Eating, Sleeping, Hearing, Seeing, Breathing)

Dietary Accommodations

Foods to Omit	Foods to Substitute

Specify texture modifications below and desribe above if necessary:

☐ None ☐ Chop ☐ Ground ☐ Puree ☐ Thickened

☐ Other:____________________

For USDA Food Programs providing milk, the child can consume (check all that apply below):

☐ Lactose Free ☐ USDA-approved Soy Milk* ☐ None, please explain below:

*8th Continent (Original), Pacific Ultra (Plain), Great Value (Original), Kirkland Organic (Plain), Silk (Original)

Specify milk substitution(s):____________________

Describe any other concerns regarding the child's eating or feeding patterns: ☐ None

____

Signed by Recognized Medical Authority [Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PA), Nurse Practitioner (ARNP), or Naturopathic Physician (NP)]

____

Health Care Provider's Signature Date