Child's Name:_____

Authorization for Emergency Care of Children with Severe Allergies

Dear Doctor: _____ Date:_____

Your patient, _____ is enrolled in the part-time preschool program at East Columbia Preschool (ECP). ECP has been requested to provide certain emergency care for the prevention of anaphylaxis in the event this child comes into contact with a certain allergen(s), as described below. Please complete Part I of the attached instruction record. This record will remain in the child's file at ECP so that ECP staff may assist with the allergy care and needs of our enrollee/your patient. If you need to provide further instructions or clarification, please do so on 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 ECP. Thank you for your cooperation.

****

Part I (to be completed by physician)

Child's Name:_____ Birth Date:_____

Child's Physician_____ Phone:_____

Address:_____

Physician's emergency contact number:_____

Allergens:

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
- ☐ Insect bite(s). Identify:_____
- ☐ Animal fur. Identify: _____
- ☐ Food allergy. Identify ALL foods that must be avoided:

  _____
- ☐ Other allergen(s). Identify:_____

Child's Name:_____

Symptoms:

Please provide a complete list of the symptoms that indicate that the child has come into contact with an allergen and that she/he consequently requires emergency treatment.

- ☐ Shortness of breath or difficulty breathing
- ☐ Swelling of the face and/or lips
- ☐ Hives
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Other. Explain:_____

Procedures:

Please indicate all steps necessary and the order in which they should be taken.

Order of treatment	Procedure
	Give Benadryl Elixir, _____ml, orally
	Administer EpiPen, Jr. or _____
	Call 911
	Call child's parent(s)/guardian(s) at _____
	Call child's physician at _____
	Other. Explain: _____
	Do not administer medication in the absence of known exposure to allergens. Explain:_____

Recreation Activities:

1. This child may [ ] may not [ ] participate in recreational activities.
2. Does this child have any activity restrictions [ ] yes [ ] no
   if yes, explain, _____

Completed by:

Physician's Signature:_____ Date: _____

Child's Name:_____

****

Part II (to be completed by child's parents)

Parent's Name:_____

Address:_____

Phone:_____

Emergency contact number:_____

Parent's Name:_____

Address:_____

Phone:_____

Emergency contact number:_____

By signing this form, we, _____ authorize East Columbia Preschool, Inc., to follow the physician's instructions contained in the above authorization form for the care of our child, _____.

We agree to update this form as medical needs change or dictate.

Parent's Signature:_____ Date: _____

Parent's Signature:_____ Date: _____