UMCHS - SEVERE ALLERGY AND FOOD SUBSTITUTION PROTOCOL

(To Be Completed by Child's Parent and Physician)

Child's Name: ________________________________ Date of Birth: ______________

Provider Name: ________________________________ Telephone: ______________

Has child ever seen a physician for allergy concerns? If so, please explain: ______________

Has allergy been "diagnosed" by child's physician? Yes No If "Yes", what was the diagnosis and when was it made? ______________

Has child ever been hospitalized for a severe allergic reaction? Yes No If "Yes" please explain: ______________

EMERGENCY ACTION is necessary when child has symptoms such as: ______________

MEDICATIONS should be administered by Head Start staff when: ______________

Give MEDICATIONS as follows:

Name of Medication	Method of Administration	Dosage	Frequency of Use-When to use

Check for possible side effects such as: ______________

IF CHILD SHOWS ANY SIGNS OR SYMPTOMS OF ANAPHYLAXIS STAFF MUST CALL 911 AND INITIATE THE EMERGENCY MEDICAL RESPONSE SYSTEM AS WELL AS CONTACT THE CHILD'S PARENTS.

For purposes of this protocol "severe allergy" refers to any allergic reaction where exposure to the allergen or causative agent is know to be or may become "life threatening". Any reaction where symptoms of "Anaphylaxis" are present, such as; tightness of chest or throat, breathing difficulty, wheezing, swollen or blue lips, swollen tongue or throat, hives or rash, shall be considered "life threatening" .

Special Instructions: ______________

I request and authorize this **EMERGENCY PROTOCOL** to be followed for the period commencing with the______day of_____, 20___, through the_____day of______, 20___, as there exists a valid health reason which makes enacting such protocol necessary. In all cases emergency protocol for allergy shall be reviewed by Head Start staff annually.

Physician Signature: ______________ Date: ______________

Parent Signature: ______________ Date: ______________

(My signature signifies consent for UMCHS staff to enact the emergency procedures identified by my child's physician and in accordance with the time frames listed above, not to exceed one year.)

MEDICAL STATEMENT FOR FOOD SUBSTITUTIONS

Medication Condition that requires child to have Food Substitution(s): ______________

Food to be Omitted: ______________

Recommended Food Substitution: ______________

I certify that the above named child requires the food substitutions(s) as described for medical reasons:

Print Name and Title: ______________

Recognized Medical Authority Signature: ______________ Date: ______________

(A "Recognized Medical Authority" is a Licensed Physician (MD), Physician's Assistants (PA), Registered Dietitians (RD), Nurse Practioners (NP), Registered Nurses (RN), Naturopathic Physician (NP), Doctor of Osteopathy (DO), and Naturopathic Doctor of Osteopathy (NDO).

Child/Family Advocates are responsible for ensuring substitute staff are informed of procedures outlined within this allergy and food substitution protocol.

Maintain completed original in Center File with copies to Emergency Contact Binder and HSD.