



ISSAQUAH CHILDREN'S ACADEMY
EARLY CHILDHOOD DEVELOPMENT SPECIALISTS

Health Care Provider's Allergy/Intolerance Report

Name Of Child

Today's Date

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

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

As a licensed child care program we are required to meet state licensing standards. Please help us to comply and meet the health needs of your patient by completing the Allergy/Intolerance Statement form and if necessary the Child Care Emergency Plan for Allergic Reactions. We need to know which items the child is allergic or intolerant to, the steps to take to treat an allergic reaction, and appropriate substitute foods to assure that the child's nutrition is not compromised.

Thank you for your help in this important health matter.
Sincerely,

Child Care Program Director

Child Care Site

Child Care Center Address

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

Parent/Guardian Signature

Date

Parent/Guardian Name (print)

Parent/Guardian Address



Name of Child _____ Birthdate _____

(Please print)

Food Allergy: List each food separately	Check the medical condition	List appropriate substitute food(s)
	Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Yes No Food Allergy <input type="checkbox"/> <input type="checkbox"/> *Yes No	
	Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Yes No Food Allergy <input type="checkbox"/> <input type="checkbox"/> *Yes No	
	Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Yes No Food Allergy <input type="checkbox"/> <input type="checkbox"/> *Yes No	
	Food Intolerance <input type="checkbox"/> <input type="checkbox"/> Yes No Food Allergy <input type="checkbox"/> <input type="checkbox"/> *Yes No	

Other Allergy: Please list items:	Reaction: Mild <input type="checkbox"/> <input type="checkbox"/> Yes No Severe <input type="checkbox"/> <input type="checkbox"/> Yes No	Plan for management:
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* For an Allergy, please complete the Child Care Emergency Plan for Allergic Reactions.

Health Care Provider Name _____

Health Care Provider Signature _____ Date _____

Mailing Address (Print) _____ Phone _____

Please return to the child care program at the address listed below:
