CONNECTION POINT
EARLY LEARNING CENTER

AUTHORIZATION FOR EMERGENCY CARE OF CHILDREN WITH SEVERE ALLERGIES

This information pertains to the 20___ - 20___ academic year.

PART I: To be Completed by a Physician (Please Print)

Child's Name: _____ DOB: _____

Allergens

Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction (i.e: anaphylactic shock).

_____ Bee Sting

____ not sure, never been stung ____ been stung #___ times

_____ Other Insect Bite(s), be specific: _____

_____ Animal Fur, be specific: _____

_____ Food Allergy, specify ALL foods that must be avoided:

_____

_____

_____

_____

_____ Other: _____

Symptoms

Please provide a complete list of all symptoms that indicate the child has come in contact with an allergen and requires emergency treatment.

_____ Shortness of Breath or Difficulty Breathing
_____ Swelling of the Face and/or Lips
_____ Hives
_____ Vomiting
_____ Diarrhea
_____ Other: _____

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Procedures

Please indicate all of the necessary steps **in the order they should be taken** (number the steps in the correct order).

_____ Give Benadryl: _____mL orally when the child shows the following symptoms:

_____

_____

_____ Administer EpiPen Jr. and/or inhaler when the child shows the following symptoms: _____

_____

List specific step-by-step instructions for administration of EpiPen and or inhaler (more detailed than "give as directed"): _____

_____

_____

_____ Call 911

_____ Call parent(s)/guardian(s). List ALL possible contact numbers in the order we should try calling, indicating home/cell/work and mom/dad/relative:

_____

_____

_____

_____

_____

_____ Other: _____

Recreational Activities

The child may participate in all activities: _____ Yes _____ No

If no, please explain restrictions: _____

_____

Child's Physician: _____

Address: _____ Phone #: _____

Doctor's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

PART II: To be Completed by the Child's Parent(s) or Legal Guardian(s)

By signing this form, I/We authorize Connection Point Early Learning Center to follow the instructions contained in this Authorization for Emergency Care of Children with Severe Allergies form. I/We agree to update this form every year or sooner if my/our child's needs change.

Parent(s) / Legal Guardian(s):

Name: _____ Relationship: _____

Address: _____

Phone #: _____ Cell Phone #: _____

Emergency Contact #: _____

Signature: _____ Date: _____

Name: _____ Relationship: _____

Address: _____

Phone #: _____ Cell Phone #: _____

Emergency Contact #: _____

Signature: _____ Date: _____

PART III: To be Completed by Connection Point

This completed Authorization for Emergency Care of Children with Severe Allergies Form was received by Connection Point on: _____

This Form must be updated by: _____

Received By: (Print Name) _____

Signature: _____ Date: _____