This page to be completed by:
Program Staff and Parent or Guardian

Public Health
Seattle & King County

Food Intolerance Care Plan Request Form

Child's name: ____________________

Child's date of birth: ____________________

Early Learning or Child Care Program Director: ____________________

Early Learning or Child Care Program: ____________________

Mailing Address: ____________________

Phone Number: ____________________

Fax Number: ____________________

Healthcare Provider: The child listed above attends our program. This packet includes forms to help meet our licensing standards for medications and individual care plans. **Please complete pages 2-3.** These are forms that require a healthcare provider's instructions and signature.

If the child has a diagnosed food allergy, please contact the program listed above to request the Allergy Care Plan Packet.

By signing below, I give permission to my child's healthcare provider to release the health information requested in the following care plan to my child's program.

Parent or Guardian Name (Printed): ____________________

Parent or Guardian Signature: ____________________

Date: ____________________

Parent or Guardian Phone Number: ____________________

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Food Intolerance Care Plan

Child's name: ______________________________

Child's date of birth: ______________________________

Healthcare Provider: The WAC requires written instructions from a licensed healthcare provider for any child with a known special dietary requirement due to a health condition. **Please fill out the following information, including symptoms, appropriate food substitutions, and emergency response plans.**

Food Intolerance (List each food separately)	**Symptoms of Intolerance**	**Appropriate Food Substitutions**

Emergency Response Plan

Call parent or guardian if the following symptoms are present:
Call 911 Emergency Medical Services (EMS) and emergency contacts if the following symptoms are present:
Steps to take while waiting for EMS to arrive:
Additional healthcare provider notes:

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Food Intolerance Care Plan (Continued)

By signing below, I attest the child above does not have a diagnosed allergy to the food(s) listed on page 2.

Healthcare Provider Name (Printed): ______________________________

Healthcare Provider Signature: ______________________________

Healthcare Provider Phone Number: ______________________________

Date: ______________________________

Parent or Guardian: The WAC requires written and signed consent from a child's parent or guardian before a program follow a care plan that is completed by a licensed healthcare provider.

By signing below, I give the program permission to follow this care plan as ordered by the licensed healthcare provider. **I confirm that the foods listed on this care plan are not related to a diagnosed food allergy.**

Parent or Guardian Name (Printed): ______________________________

Parent or Guardian Signature: ______________________________

Date: ______________________________

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Emergency Contact Information

Child's name: ______________________________

Parent or Guardian: If your child has a medical emergency, program staff need to be able to contact you or another emergency contact as quickly as possible. Please complete the following:

Emergency Contact #1

Name: ______________________________

Relationship to Child:______________________________

Phone Number:______________________________

Emergency Contact #2

Name: ______________________________

Relationship to Child:______________________________

Phone Number:______________________________

Emergency Contact #3

Name: ______________________________

Relationship to Child:______________________________

Phone Number:______________________________