Child Health Plan and Provider Orders
Dietary Accommodations – Food Allergies/Intolerances

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Center:	☐ ECEAP	☐ Head Start	☐ Early Head Start
Child's Name:	**Date of Birth:**		Gender: ☐ M ☐ F
Parent/Guardian:	**Phone:** (Home)		(Cell)
Does this child have any of the following? (check one)	☐ IEP	☐ IFSP	☐ 504 Plan

If your child is exposed to or eats a food/ingredient that must be avoided, staff should:

☐ Call 911 immediately if severe symptoms ☐ Call parent ☐ Send note home with child

Severe Symptoms

Lung
Shortness of breath, wheezing, repetitive cough

Heart
Pale or bluish skin, faintness, weak pulse, dizziness

Throat
Tight or hoarse throat, trouble breathing or swallowing

Mouth
Significant swelling of the tongue or lips

Skin
Many hives over body, widespread redness

Gut
Repetitive vomiting, severe diarrhea

Other
Feeling something bad is about to happen, anxiety, confusion

Anaphylaxis Action Plan

- **If prescribed, administer epinephrine as ordered (Epi-pen Jr., Auvi-Q, Twinject).**
- **Call 911 immediately!** 911 must be called whenever an epinephrine auto-injector is administered.
- Advise 911 that child is having a severe allergic reaction and the Epinephrine is being administered.
- A CPR-trained adult must remain with child at all times, at the location where symptoms began until EMS arrives. Begin CPR if necessary.
- Call School Nurse or Health Office per your school district policy.
- Give used epinephrine auto-injector to EMS along with a copy of the *Child Health Plan.*

Mild Symptoms

Nose
Itchy or running nose, sneezing

Mouth
Itchy mouth

Skin
A few hives, mild itch

Gut
Mild nausea or discomfort

For mild symptoms

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the child and call emergency contacts.
3. Watch closely for changes. If symptoms worsen, call 911.

Child's Name: **Date of Birth:** **Gender:** ☐ M ☐ F

To be completed by Health Care Provider with the Parent/Guardian:

Federal law and USDA regulation require nutrition programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, which can include allergies and digestive conditions, but does not include personal diet preferences.

List all of the food items or ingredients that your child is allergic to, intolerant of, or needs to avoid for a medical condition below. For each food item/ingredient you list to avoid, please list possible substitutes, check if symptoms are severe or mild and what the symptoms are, and if medication is required.

Food Allergies/Food Intolerances:

Food/ingredient to avoid: ☐ Avoid completely ☐ Can tolerate trace amounts in foods (e.g., no eggs, but ok in baked goods) **List food substitutions:**	**My child's symptoms are:** ☐ Life Threatening/Severe ☐ Mild **Check all that apply:** ☐ Shortness of breath ☐ Rash ☐ Vomiting ☐ Itching ☐ Diarrhea ☐ Wheezing ☐ Swelling ☐ Stomach pain ☐ Dizziness ☐ Redness ☐ Gas ☐ Hives ☐ Nausea ☐ Bloating ☐ Other:	**Is medication required if the food is consumed?** ☐ Yes ☐ No If yes, specify:
Food/ingredient to avoid: ☐ Avoid completely ☐ Can tolerate trace amounts in foods (e.g., no eggs, but ok in baked goods) **List food substitutions:**	**My child's symptoms are:** ☐ Life Threatening/Severe ☐ Mild **Check all that apply:** ☐ Shortness of breath ☐ Rash ☐ Vomiting ☐ Itching ☐ Diarrhea ☐ Wheezing ☐ Swelling ☐ Stomach pain ☐ Dizziness ☐ Redness ☐ Gas ☐ Hives ☐ Nausea ☐ Bloating ☐ Other:	**Is medication required if the food is consumed?** ☐ Yes ☐ No If yes, specify:
Food/ingredient to avoid: ☐ Avoid completely ☐ Can tolerate trace amounts in foods (e.g., no eggs, but ok in baked goods) **List food substitutions:**	**My child's symptoms are:** ☐ Life Threatening/Severe ☐ Mild **Check all that apply:** ☐ Shortness of breath ☐ Rash ☐ Vomiting ☐ Itching ☐ Diarrhea ☐ Wheezing ☐ Swelling ☐ Stomach pain ☐ Dizziness ☐ Redness ☐ Gas ☐ Hives ☐ Nausea ☐ Bloating ☐ Other:	**Is medication required if the food is consumed?** ☐ Yes ☐ No If yes, specify:
Food/ingredient to avoid: ☐ Avoid completely ☐ Can tolerate trace amounts in foods (e.g., no eggs, but ok in baked goods) **List food substitutions:**	**My child's symptoms are:** ☐ Life Threatening/Severe ☐ Mild **Check all that apply:** ☐ Shortness of breath ☐ Rash ☐ Vomiting ☐ Itching ☐ Diarrhea ☐ Wheezing ☐ Swelling ☐ Stomach pain ☐ Dizziness ☐ Redness ☐ Gas ☐ Hives ☐ Nausea ☐ Bloating ☐ Other:	**Is medication required if the food is consumed?** ☐ Yes ☐ No If yes, specify:

If there are additional food items, please copy this page and attach to this form.

This page is to be completed by the Health Care Provider.

Child's Name: _____ **Date of Birth:** _____ **Gender:** ☐ M ☐ F

Other Non-Allergy Dietary Accommodations/Modifications:

Does the child have a special nutritional or feeding need/concern that is not a food allergy or intolerance?

☐ Yes – Please describe the condition or need: _____

Explain what must be done to accommodate the child's diet [i.e., specific food(s) to be omitted/avoided or added to/from child's diet]:

_____

List food(s) and/or beverages to be substituted, provided, or modified:

_____

Specify texture modifications below and describe if necessary:

☐ None ☐ Chop ☐ Ground ☐ Puree ☐ Thickened ☐ Other: _____

☐ No

☐ **No medication is required at school (Skip box and sign on the next page if you agree with this *Child Health Plan*).**

☐ **Medication is required at school (Fill out box below and sign on the next page). If medication is taken daily at home, a 3-day supply of medication is needed at school in case of a disaster.**

Health Care Provider Orders for Medication at School **Important notice to Provider:** Please ensure this child has a prescription on file with the pharmacy that matches the orders below. Our policy requires Health Care Provider Orders and medication labels to match exactly.	
1) Medication Name	**2) Symptoms for medication use**
3) Dose	**4) Frequency & Length of time between doses** **5) Route**
6) Possible side effects of medication	
7) Special administration and/or storage instructions	
8) If PRN, start date **and end date** **required.**	

Head Start | Washington State Department of CHILDREN, YOUTH & FAMILIES

Signature of State-Recognized Medical Authority[1]	**Date**
Print Name	**Phone #** **Fax #**
Parent/Guardian Signature	**Date**
Interpreter Signature	**Date**
Nurse Consultant Signature	**Date**

ITE/Teacher	**Date**	**ITP/Assistant**	**Date**	**FA/FE/FSS/HV**	**Date**	**Dir/C Coor**	**Date**

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   Program.Intake@usda.gov

This institution is an equal opportunity provider.

[1] State-Recognized Medical Authority is a licensed health care professional authorized to write medical prescriptions in Washington: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PA) with prescriptive authority, Naturopathic Physician, or Advanced Registered Nurse Practitioner (ARNP).