



**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

# Allergy/Intolerance Statement

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

**(Please print)**

<b>Food Allergy: List each food separately</b>	<b>Check the medical condition</b>	<b>List appropriate substitute food(s)</b>
	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	

<b>Other Allergy: Please list items:</b>	<b>Reaction:</b> Mild <input type="checkbox"/> <input type="checkbox"/> Yes    No Severe <input type="checkbox"/> <input type="checkbox"/> Yes    No	<b>Plan for management:</b>
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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:**

\_\_\_\_\_

