**Special Diet & Allergy Health Action Care Plan**

Child’s Name DOB

 Head Start Early Head Start Center \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Class \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Risk Factors (Parent or Physician should complete) Asthmatic ❏No ❏**YES, Asthma Action Plan also needed.**

* This child has the following special diet, food allergy or medical allergy:
	+ Special Diet/Food Intolerance:
		- Medical
	+ Food Allergy:
		- Ingestion  Absorption  Inhalation
	+ Medical Allergy:
		- Insect Sting  Latex  Medication  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNS OF AN ALLERGIC REACTION**

**\*\*The severity of symptoms can quickly change. All “starred” symptoms can potentially progress to a life- threatening situation.**

**Systems: Symptoms:**

**Skin:** Hives, itchy rash, swelling of the face, arms, or legs

**Gut:** Nausea, abdominal cramps, vomiting, diarrhea

**Mouth:** Itching & swelling of the lips, tongue, or mouth

**Throat:\*** Itching/tightness in the throat, hoarseness, hacking cough

 **Lungs:\*** Shortness of breath, repetitive coughing, wheezing

**Heart:\*** “Thready” pulse, “passing-out”, pale, blueness

**Other**

ACTION

**TREATMENT/EMERGENY CARE PLAN OF ACTION** (**Must be completed by the child’s Medical Provider)**

* + No treatment required. Contact parent/guardian if exposed to allergen.
	+ Allergen substitution required as described:
	+ If ingestion or contact with the allergen is suspected and *NO symptoms* are evident do the following:

* + If ingestion or contact with the allergen is suspected and/or symptoms include:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give

(medication/dose/route)

* + **If symptoms worsen and include:**

Give **IMMEDIATELY!**

(medication/dose/route)

# Call

* + - 911(ask for advanced life support)
		- The child’s parent or guardian.

 **(Medication Authorization from a licensed provider must be completed also if medication prescribed.)**

Parent Signature Date

Health Care Provider & Title Date

Date received by RCCDC \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reviewed and received by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MENU REVISION DOCUMENTATION FORM**

**Child’s Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Child’s DOB:**  \_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Center**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Class**: \_\_\_\_\_\_\_\_\_\_\_\_

**Food(s) allergic to or for religious restriction:**

 \_\_\_\_\_\_Milk \_\_\_\_\_\_Strawberries \_\_\_\_\_\_Peanuts/peanut butter

 \_\_\_\_\_\_Eggs \_\_\_\_\_\_Tomatoes \_\_\_\_\_\_Soybeans

 \_\_\_\_\_\_Fish \_\_\_\_\_\_ Corn \_\_\_\_\_\_Wheat

 \_\_\_\_\_\_Shellfish \_\_\_\_\_\_Oranges \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other

 \_\_\_\_\_\_Pork \_\_\_\_\_\_Walnuts/other tree nuts ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of reactions**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Severity of reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Mild \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Severe

**Degree of menu change needed:**

* Total elimination of food item \_\_\_\_\_\_\_\_\_
* Partial restriction to (number/amount) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ servings per day.
* **If milk allergy**:
1. Substitute fluid milk with lactose-free milk \_\_\_\_\_\_\_\_\_ b. Replace with nutritional equivalent to cow’s milk\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Replace with other milk-free product (such as soy milk or other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. May have cheese and yogurt \_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_No

e. May have milk baked into products \_\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_No

* **If egg allergy**:
1. May have baked products that have egg as an ingredient(ex. Cookies) \_\_\_\_\_Yes \_\_\_\_\_No

 b. Eliminate whole egg \_\_\_\_ Eliminate egg white only \_\_\_\_\_\_\_ Eliminate yolk only \_\_\_\_

Other Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Signature of Parent/Legal Guardian Date Signature of Physician Date**

 **(Signature of physician not needed if separate allergy statement) obtained**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family Advocate Date**

***\*****Physician’s statement not required for religious**restrictions*