

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

## 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 (WAC 110-300-0215 and 110-300-0300). **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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Healthcare Provider

# 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:** \_\_\_\_\_

This page to be completed by:  
Parent or Guardian

## 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: \_\_\_\_\_