



AUTHORIZATION FOR EMERGENCY CARE FOR CHILDREN WITH SEVERE ALLERGIES

Dear Doctor: _____ **Date:** _____

Your patient, _____ is enrolled / enrolling in our child care center and we have been requested to provide certain emergency care for asthma. Please complete Part I of this instruction record. This record will remain in the child's file at Little Learners Academy so we may assist with the allergy care and needs of our enrollee and your patient. If you need to provide further instructions or clarifications, please do soon a separate sheet of paper, which will become a part of this record and will be kept with this form in the child's file at _____.

PART I (to be completed by physician)

Child's Name: _____ Child's Birth Date: _____

Allergens: Please provide a complete list of all events and/or substances that may trigger an asthma attack in the child.

___ Bee Sting

___ Other insect Bite(s): (identify): _____

___ Animal Fur: (identify) _____

___ Food Allergy: (identify all foods that must be avoided): _____

___ Other: (identify) _____

Symptoms: Please provide a complete list of all symptoms that indicate that the child is having an asthma attack and that he or she requires emergency treatment.

___ Shortness of Breath or Difficulty in Breathing

___ Swelling

___ Hives

____ Vomiting

____ Other: (explain): _____

Procedures: Please indicate all steps necessary and the order in which they should be taken.

____ Give inhaler.

____ Call the area's emergency medical personnel (e.g. "911").

____ Call parent(s)/guardian(s), and child's physician.

____ Other: (explain): _____

Recreational Activities:

1. The child may participate in recreational activities. [] Yes [] No

2. Activity restrictions:

[] None [] Some Restrictions (explain): _____

Child's Physician:

Name: _____

Address: _____

Telephone No.: _____

Emergency Contact No.: _____

Signature: _____ Date: _____

PART II (to be completed by Parent/Guardian's)

Parent(s)/Guardian(s)

Name: _____

Address: _____

Telephone No.: _____

Emergency Contact No.: _____

Name: _____

Address: _____

Telephone No.: _____

Emergency Contact No.: _____

By signing this form, I\We authorize Little Learners Academy to follow the above instructions in the Authorization form. I\We agree to update this form every six (6) months or sooner if my/our child's needs change.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____