UMCHS - SEVERE ALLERGY AND FOOD SUBSTITUTION PROTOCOL

(To Be Completed by Child's Parent and Physician)

Child's Name: Pedro Estevan Date of Birth: 8/22/05

Provider Name: Dr Smith Telephone: 567-2945

Has child ever seen a physician for allergy concerns? If so, please explain: yes, after emergency room visit, had allerg testing in '03

Has allergy been "diagnosed" by child's physician? Yes ☒ No ☐ If "Yes", what was the diagnosis and when was it made? Severe Peanut Allergy

Has child ever been hospitalized for a severe allergic reaction? Yes ☒ No ☐ If "Yes" please explain: At age two - rushed to emergency room

EMERGENCY ACTION is necessary when child has symptoms such as: Itchy watery eyes, swollen lips or face, trouble swallowing, throat cloting

MEDICATIONS should be administered by Head Start staff when: when any of above symptom occur or child has eaten peanuts

Give MEDICATIONS as follows:

Name of Medication	Method of Administration	Dosage	Frequency of Use-When to use
epi-pen jr	subcutaneous	1 dose	when above symptoms not relieved by benad.
benadryl	oral	1 tsp	when symptoms begin

Check for possible side effects such as: benadryl - drowsiness

IF CHILD SHOWS ANY SIGNS OR SYMPTOMS OF ANAPHYLAXIS STAFF MUST CALL 911 AND INITIATE THE EMERGENCY MEDICAL RESPONSE SYSTEM AS WELL AS CONTACT THE CHILD'S PARENTS.

For purposes of this protocol "severe allergy" refers to any allergic reaction where exposure to the allergen or causative agent is know to be or may become "life threatening". Any reaction where symptoms of "Anaphylaxis" are present, such as; tightness of chest or throat, breathing difficulty, wheezing, swollen or blue lips, swollen tongue or throat, hives or rash, shall be considered "life threatening".

Special Instructions: Contact parent if any medication is needed

I request and authorize this **EMERGENCY PROTOCOL** to be followed for the period commencing with the 19 day of 8, 2009, through the 19 day of 8, 2010, as there exists a valid health reason which makes enacting such protocol necessary. In all cases emergency protocol for allergy shall be reviewed by Head Start staff annually.

Physician Signature: Providers Signature (Sample FORM) Date: 8/19/09

Parent Signature: Juanita Estevan Date: 8/26/09

(My signature signifies consent for UMCHS staff to enact the emergency procedures identified by my child's physician and in accordance with the time frames listed above, not to exceed one year.)

MEDICAL STATEMENT FOR FOOD SUBSTITUTIONS

Medication Condition that requires child to have Food Substitution(s): peanut allergy

Food to be Omitted: Any food contains peanuts or processed with peanuts

Recommended Food Substitution:

I certify that the above named child requires the food substitutions(s) as described for medical reasons:

Print Name and Title: Providers Signature (SAMPLE FORM)

Recognized Medical Authority Signature: [signature] Date: 8/19/09

(A "Recognized Medical Authority" is a physician, physician's assistant, nurse or a registered dietitian.)

Child/Family Advocates are responsible for ensuring substitute staff are informed of procedures outlined within this allergy and food substitution protocol.

Maintain completed original in Center File with copies to Emergency Contact Binder and HSD.

(NOT A REAL PROTOCOL)