Charlotte Jewish Preschool
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CJP Allergy Communication Form

Child Name: _____

Food Allergy/Allergies: _____

Medical Diagnosis: _____

Forms

(Hang inside of cabinet)

- ☐ HIPAA Letter (permission to post)
- ☐ Permission to administer
- ☐ Food Allergy Action Plan (signed by doctor)
- ☐ Medical Action Plan (signed by doctor)

Medications (all medications must be on the action plan signed by doctor)

- ☐ 2 epi-pens in cabinet unlocked and 5 ft. up
- ☐ Antihistamine (ex: Zyrtec, Claritin, Benadryl)
- ☐ Other Medication: _____

Environmental Accommodations

- ☐ Environmental accommodations not necessary
- ☐ Allergy (food)_____ free primary classroom
- ☐ Allergy (food)_____ free table (table labeled with name and allergy, cleaned table tops, lunches checked)

Special Days/Events/Facilities

Special days at the CJP often involve foods that are not typically served in their classroom. On special days we ask that the parent either attend the special day with their child, or make accommodations in order to ensure their child's safety. Furthermore, parents will provide teachers with supplemental snacks if their child is not able to eat special snacks due to their allergy. CJP utilizes facilities outside of the primary classroom, including at the Levine Jewish Community Center. If an allergy free primary classroom is checked above, **only that classroom will be allergy free.** Your child may spend time in other classrooms in the school building and other facilities on our campus, those environments will not be allergy free. If you sign your child up for a "special" at the LJCC, you are

responsible for providing the necessary medication. CJP will not transfer any medication from our premises.

Accommodations:

_____

_____

_____

A copy of CJP's Allergy Policy is attached. I acknowledge that I have read and understand the CJP Allergy Policy. Furthermore, I understand the above sets forth CJP's responsibility with respect to my child's allergy. I acknowledge that despite the good faith efforts by CJP, our child may encounter allergens or other environmental agents in the CJP premises due to the nature of the school environment and exposure to other children. I waive the right to any suit or complaint, claim, charge, demand or damages against CJP, its affiliates and any of their employees, teachers, staff members, agents, independent contractors, officers, or directors arising from such exposure, unless such exposure results from the gross negligence of CJP.

Parent(s) Name(s):

Signature: _____Date:_____

Signature: _____Date:_____

CJP Acknowledges receipt of this Allergy Communication Form on the date set forth below.

Administrator:

Signature: _____

Name: _____

Title: _____

Lead Teacher in Primary Classroom:

Signature: _____

Name: _____

Title: _____

Date Received: _____

Charlotte Jewish Preschool
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Dear Parents,

It is noted on your child's health assessment that _____ has an allergy to

_____ and/or a medical condition of _____.

Under the HIPAA Privacy Law your child's medical records and health information are protected and remain confidential at all times. The Charlotte Jewish Preschool honors this law and respects every child's privacy pertaining to his/her medical records. However, at the Charlotte Jewish Preschool, we feel that in order to protect your child to the best of our ability, it is important to post the allergy and plan of action in a visible place in the classroom. We want all of the adults interacting with your child to have access to this information, therefore able to prevent any allergic reaction and/or respond promptly and appropriately to any allergic reactions that may occur. Please indicate below if you give the Charlotte Jewish Preschool permission for your child's allergies and their action plan to be posted in the classroom.

Name of Parent(s):_____, _____

Child's Name: _____ Allergy_____ Medical Condition: _____

_____I hereby give permission to the Charlotte Jewish Preschool to post any information pertaining to my child's allergy and plan of action in the classroom

_____I do not give permission to the Charlotte Jewish Preschool to post any information pertaining to my child's allergy and plan of action in the classroom

Signature_____ Date: _____

Powered By Jewish Federation of Greater Charlotte

Child Medical Action Plan

10A NCAC 09 .0801(b) [Centers] and .1721(a)(4) [Family Child Care Homes]

If a child has health care needs that require specialized health services, the child's a health care professional or parent/guardian must complete a medical action plan and attach it to the child's application. This plan must be updated both annually and anytime there are changes to the child's health status or treatment plan. It is recommended that parents do not complete or change the plan without guidance from the child's health care professional.

The medical action plan must be attached to the application, included in the facility Read to Go File, and accessible to the staff caring for the child.

Children with asthma, diabetes, seizures, or allergies should have medical action plans specific to those conditions.

Name of person completing form:		Today's date:
Child's full name:		Date of birth:
Parent/guardian's name:		Phone:
Primary health care professional:		Phone:
Specialist/therapist:	Type:	Phone:
Specialist/therapist:	Type:	Phone:
Diagnosis(es):		
Allergies (food, medication, environmental, insects, or other):		

Medication(s)

Complete a **Medication Administration Permission Form** if medications listed below are to be provided by the child care. Complete page three if child has more than two medications.

Medication name:	☐ Daily medication taken at child care	☐ Daily medication taken at home	☐ Emergency medication
Dosage:	Time/frequency:	Route:	
Special instructions:	Side effects:	Reason prescribed:	

Medication name:	☐ Daily medication taken at child care	☐ Daily medication taken at home	☐ Emergency medication
Dosage:	Time/frequency:	Route:	
Special instructions:	Side effects:	Reason prescribed:	

Accommodation(s)

Describe any accommodation(s) the child needs in daily activities and why.

Diet or Feeding:
Classroom Activities:
Naptime/Sleeping:
Toileting:
Outdoors or Field Trips:
Transportation:
Other/Comments:

NORTH CAROLINA
Child Care Health and Safety Resource Center
800-367-2229
healthychildcare.unc.edu

Child Medical Action Plan

Equipment/Medical Supplies

1.
2.
3.
4.

Emergency Care

Call parents/guardians if the following symptoms are present:
Call 911 (emergency medical services) if the following symptoms are present, and contact the parents/guardians:
Take these measures while waiting for parents or medical help to arrive:

Suggested Special Training for Staff

If completed by a health care professional:

Health Care Professional Signature:	Date:

Parent notes

Parent/Guardian Signature:	Date:

NORTH CAROLINA
Child Care Health and Safety Resource Center
800-367-2229
healthychildcare.unc.edu

Child Medical Action Plan

Medication name:	☐ Daily medication taken at child care	☐ Daily medication taken at home	☐ Emergency medication
Dosage:	Time/frequency:	Route:	
Special instructions:	Side effects:	Reason prescribed:	
Medication name:	☐ Daily medication taken at child care	☐ Daily medication taken at home	☐ Emergency medication
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Special instructions:	Side effects:	Reason prescribed:	
Medication name:	☐ Daily medication taken at child care	☐ Daily medication taken at home	☐ Emergency medication
Dosage:	Time/frequency:	Route:	
Special instructions:	Side effects:	Reason prescribed:	

Medical Action Plan - Asthma

10A NCAC 09 .0801 (centers) and .1721 (family child care homes)

If a child has asthma, the child's health care professional or parent/legal guardian must complete a medical action plan and attach it to the child's application. This plan must be updated both annually and anytime there are changes to the child's health status or treatment plan. It is recommended that parents do not complete or change the plan without guidance from the child's health care professional.

The medical action plan must be attached to the application, included in the facility Read to Go File, and accessible to the staff caring for the child.

Name of person completing form:	Today's date:
Child's full name:	Date of birth:
Parent/guardian:	Phone:
Primary Health Care Professional name:	Phone:
Primary Health Care Professional signature:	

Asthma Triggers (Avoid exposure to triggers)				**Severity of asthma**
□ Carpet	□ Mold	□ Cockroaches	□ Changes in weather	□ Mild intermittent
□ Animals	□ Pollen	□ Chemical sprays	□ Illness	□ Mild persistent
□ Tobacco smoke	□ Dust (mites)	□ Strong odors	□ Other:_____	□ Moderate persistent
				□ Severe persistent
List Allergies:				

Consult with a Child Care Health Consultant about this plan.

GREEN - GO
Child is breathing well.

No cough or wheeze.

Sleeps well at night.

Plays actively.

No early warning signs.

Use these long-term CONTROL medicines **every day** to keep child in the green zone.

Medicine:	How much to give:	When to give:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication before active play or exercise: □ None needed

□ Medication _____ Give _____ minutes before active play or exercise.

YELLOW – CAUTION
Child has some problems breathing.

Keep using long-term CONTROL green zone medicines every day. **Add** quick-relief medicines to keep asthma from becoming worse. Parent/legal guardian contacts the health care professional when quick-relief medicine is used more than twice in a week.

- Coughing
- Wheezing
- May squat or hunch over
- Chest tight
- Waking often
- Poor appetite
- Decreased play or activity

Other early symptoms (child specific):

_____

_____

_____

At Home

Medicine:	How much to give:	When to give:
Albuterol _____ OR _____	___ 2 puffs by inhaler (with spacer) ___ by nebulizer (with mask)	Give first dose as soon as possible. Repeat every ____ minutes for up to a total of ____ doses if needed.

If symptoms **return** to **Green Zone**:	If symptoms not back to **Green Zone** in 1-2 hours:
• Take quick-relief medicine every 4 hours for ___ days. • Change long-term control medicines to _____ for ___ days. • Contact health care professional if symptoms return.	Take quick-relief medication again. Contact health care professional.

At Child Care

Medicine:	How much to give:	When to give:
Albuterol _____ OR _____	___ 2 puffs by inhaler (with spacer) ___ by nebulizer (with mask)	Give first dose as soon as possible. Call parent/guardian if symptoms do not return to green zone within 15 minutes. Repeat every _____ minutes for up to a total of _____ doses if needed.

If symptoms **return** to **Green Zone:**	If symptoms not back to **Green Zone** in 1 hour:
Continue quick-relief medicine every 4 hours for remainder of time in care.	Have parent/guardian pick child up and care for the child.

Medical Action Plan - Asthma

10A NCAC 09 .0801 (centers) and .1721 (family child care homes)

<table>
<tr><th colspan="2">RED – DANGER
Child has severe problems with breathing.</th><th colspan="3">Get help!
Give quick-relief medicines until help arrives.</th></tr>
<tr><td rowspan="3">Severe Symptoms
▪ Getting worse instead of better.
▪ Coughing constantly.
▪ Cannot talk well.
▪ Cannot play or walk.
▪ Breathing is hard and fast, gasping.
▪ Nostrils open wide when child breathes.
▪ Chest muscles tight. Space between the ribs and over the chest bone suck in with each breath.
▪ Fingernails or lips blue.</td><td>CHILD HAS SEVERE SYMPTOMS!
  </td><td colspan="3">At Home</td></tr>
<tr><td>Medicine:</td><td>How much to give:</td><td>When to give:</td></tr>
<tr><td>Albuterol _____
OR _____</td><td>___ 2 puffs by inhaler (with spacer)
___ by nebulizer (with mask)</td><td>• Give a dose immediately and call health care professional.
• Repeat every ____ minutes until medical help is obtained.
• Do not leave child alone.</td></tr>
<tr><td rowspan="3">CALL 9-1-1 if symptoms last more than a few minutes.
  </td><td colspan="3">At Child Care</td></tr>
<tr><td>Medicine:</td><td>How much to give:</td><td>When to give:</td></tr>
<tr><td>Albuterol _____
OR _____</td><td>___ 2 puffs by inhaler (with spacer)
___ by nebulizer (with mask)</td><td>• Give a dose immediately.
• Call parent/guardian if not previously called.
• Call health care professional if unable to reach parent/guardian.
• Repeat dose every _____ minutes until medical help is obtained.
• Do not leave child alone.</td></tr>
</table>

Plan reviewed by:

Child Care Director/Operator name:	Date:
Signature:	

Child care staff trained to care for child:

#1:	#2:	#3:
Who will move and/or care for other children?		
Who will notify the child's emergency contact?		
Who will call and assist EMS (911) when needed?		
Who will go to the hospital when needed and stay with child until parent/legal guardian assumes responsibility?		

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Attach child's photo

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

SPECIAL SITUATION: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type):_____ Dose: ☐ 0.15 mg ☐ 0.30 mg (weight more than 25 kg)
Antihistamine, by mouth (type and dose): _____
Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: (___) _____-_____

Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____

Medication Administration Permission Form

10A NCAC 09 .0803 (centers) and .1720 (family child care homes)

Parent/guardian completes, signs, and dates the Medication Administration Permission Form. The person accepting this form must attach the Medication Administration Record(s) to this form.

Permission valid from date:	To date:

Only complete this box if the medication is for a child who has a chronic medical condition or an allergy

☐ This document is written permission to administer this medication for up to 6 months.

Specific chronic medical or allergic condition: _____

Child has an: ☐ Medical Action Plan (required)

Child's full name:	Date of birth:
Medication name:	Expiration date:

When to give medication (choose one):

☐ Give medication on these specific dates and times:

☐ Give medication as needed. List the specific symptoms or circumstances needed to give the medication and how often it can be given. Ex. If Suzy has a rash and is scratching it, apply this ointment to the rash. Wait at least 6 hours before reapplying.

Dosage (how much medication to give):
Route (how to give the medication):
Special instructions on how to give medication:
Possible reactions or side effects:
☐ Child has received at least one dose of medication at home without reactions or side effects.

Prescribing health care professional name:	Phone:
Pharmacy:	Phone:

I give authorization to give medicine and to call the prescribing health care professional or pharmacy if needed

Parent/guardian name:	
Parent/guardian signature:	Date:

Medication received, returned, or disposed of:

Received from parent/guardian	Date	Amount	Parent/guardian signature	Child care provider signature
Returned to parent/guardian	Date	Amount	Child care provider signature	Witness signature
Disposed of medicine	Date	Amount	Child care provider signature	Witness signature

NORTH CAROLINA
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800-367-2229
healthychildcare.unc.edu

Medication Administration Record

10A NCAC 09 .0803 (centers) and .1720 (family child care homes)

Person who gives the child the medicine completes this Medication Administration Record. Copy this page when you need more lines to record medication administration. Attach page to the Medication Administration Permission.

If an error occurs and the child requires medical attention, call 9-1-1 and/or Poison Control immediately.

Child's name:						
Medication name:						
Date given	Time given	Dose given	Route	Name of person giving medication	Signature of person giving medication	Reaction/side effect, if observed
Date	Time	Error or mishap while giving medication			Parent/guardian notified?	Child care provider signature
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	

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Medication received, returned, or disposed of:

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					☐ Yes ☐ No	
					☐ Yes ☐ No	

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