



Rhode Island Department of Human Services

Licensed Child Care: Allergy Information Form

Child Information	
Child's Name:	Date of Birth:
Is your child Asthmatic? (Yes = High Risk for Severe Reaction) <input type="checkbox"/> Yes <input type="checkbox"/> No	

Allergy Information				
Please provide as much detail regarding your child's allergies below. A child with an allergy should also have an Allergy Plan from their physician provided alongside this information form.				
Allergen	Cause of Reaction	Reaction Type	Medication on File	Notes
<i>Example: Eggs</i>	<i>Example: Ingestion</i>	<i>Example: Hives</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Epinephrine	<i>Example: Benadryl calms reaction</i>
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Epinephrine	
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Epinephrine	
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Epinephrine	

Posting Permission	
Please complete the following if any of your child's allergies are food related.	
Does the program have your permission to post your child's food allergy information in the licensed program space? (i.e. Post your child's name and food allergen in the food preparation or dining area for ease of reference by program staff)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Physician and Insurance Information	
I would prefer my child be taken to the following hospital should the need arise. However, I understand that the choice of hospital may be limited by service of the local rescue.	
Name of Doctor:	Phone:
Health Insurance Carrier:	Policy Number:

Parent/Guardian (Print)	Parent/Guardian Signature	Date