CHICAGO PARK DISTRICT'S

AUTHORIZATION FOR EMERGENCY CARE

OF CHILD WITH SEVERE ALLERGIES

Dear Doctor: _____ Date: _____

Your patient, _____ is enrolled/enrolling in a Chicago Park District program and we have been requested to provide certain emergency care for the prevention of anaphylaxis in the event the child comes into contact with a certain allergen(s), as described below. Please complete Part I of this instruction record. This record will remain in the child's file at the Chicago Park District 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 so on 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 the Chicago Park District.

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 a severe allergic reaction (i.e., anaphylactic shock) 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 has come into contact with an allergen and that he or she requires emergency treatment.

____ Shortness of Breath or Difficulty in Breathing

____ Swelling of the Face or Lips

____ Hives

____ Vomiting

____ Diarrhea

____ Other: (explain): _____

____ Do not administer medication in the absence of known exposure to allergen.

(Explain): _____

Procedures

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

____ Give Benadryl Elixir, ml orally.

____ Administer Auto-Injector, or _____

____ Call area Emergency Medical Services (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: _____