ALLERGY CARE PLAN FOR A CHILD WITH DIAGNOSED FOOD ALLERGIES

Child's Name:	**Child's Date of Birth:**
Name of the Child's Health Care Provider:	

Food Allergies:

Steps to be taken in the event of a suspected or confirmed allergic reaction:

Signature of Authorized Program Representative: I understand that it is my responsibility to follow the above plan. This plan was developed in close collaboration with the child's parent and the child's health care provider. I understand that staff who provide all treatments and administer medication to the child listed in the allergy care plan must have received Medication Administration Training; is CPR and first aid certified; or has a license that exempts them from training; and have received any additional training needed.

Provider/Facility Name:	**Facility address:**	**Facility Telephone Number:**
Authorized child care provider's name (please print)		**Date:**
Authorized child care provider's signature:		

Signature of Parent or Guardian:	**Date:**
Signature of Health Care Provider:	**Date**

Medication Authorization Form
For Prescription and Non-Prescription Medications

(8VAC20-780-510)

Section A must be completed by the parent/guardian for **ALL** medication authorizations which shall expire or renewed after 10 work days.

Section A and Section B must be completed for any **long-term prescription and over-the-counter medication which** may be allowed with written authorization from the child's physician and parent.

Sec on A: To be completed by parent/guardian

Medication authorization for: ____
(child's name)

______________________________ has my permission to administer the following medication:
(Name of Child Care Provider)

Medication name: ____

Dosage and times to be administered: ______________________________________

Special instructions (if any): ____

____

This authorization is effective from: ____________________ until: ____________________
(Start date) **(End date)**

Parent or Guardian's Signature: ______________________________ **Date:** ____________

Section B: to be completed by child's physician:

I, ____________________________________ certify that it is medically necessary for the medication(s) listed
(name of physician)

below to be administered to:____________________________________ for a duration that exceeds 10 work days.
(child's name)

Medication(s): ____

Dosage and Times to be administered: ____

Special instructions (if any): ____

____

This authorization is effective from: ________________________until: ________________________
(Start date) **(End date)**

Physician's Signature: ____

Physicians Phone: ________________________ Date: ____________________________

Revised (10/21)

Kenwood Summer Day Camp
4955 Sunset Lane ★ Annandale, Virginia 22003 ★
703-256-4711
http://camp.kenwoodschool.com

Allergy Alert Form

Camper's
Name____

Allergic
to____

What to do in case of an allergic
reaction____

I give Kenwood Summer Day Camp permission to post my child's allergies. Along with what to do in case of an emergency and where any medications are kept if medication is necessary.

Parent Signature Date