Iowa Child and Adult Care Food Program
ALLERGY/FOOD EXCEPTION STATEMENT

Description: The Child and Adult Care Food Program (CACFP) is funded by the United States Department of Agriculture (USDA). The CACFP reimburses centers for children's meals that meet USDA requirements. If an infant or child needs to avoid specific foods for a medical reason, reimbursement is allowed only if a recognized medical authority has documented the need for an exception.

Please complete this form and return to: _____
(Name of child care center)

Child's/Infant's Name: _____ Birth Date: _____

Parent's/Guardian's Name: _____

Signature of Parent: _____ Date: _____
(For permission to release information to the center)

1) Disability: Does the infant/child have a disability ? O Yes O No If yes, a physician must sign this form. If the child is not disabled the form may be signed by any of the health care practitioners listed below.

If yes, describe the major life activities affected by the disability:

2) Special Dietary/Feeding Needs: Does the infant/child have a food allergy or intolerance? O Yes O No

If yes, describe the nature of the allergy/intolerance:

Food(s) or Formula to Avoid:	**Food(s) or Formula to Substitute:**
Infants at CACFP centers must receive iron-fortified infant formula or breast milk unless an allergy/exception statement is on file.	

Other dietary or feeding needs for the infant/child:

Date for a recheck or re-evaluation: _____

Health Care Practitioner: _____ _____
Name (Print or Type) Title

[Health care practitioner must be one of the following: medical doctor (MD), doctor of osteopathic medicine (DO), physician's assistant (PA) or advanced registered nurse practitioner (ARNP)].

Address: _____

_____

_____ _____
Signature of Health Care Practitioner Date

TRAINED STAFF MEMBERS

1. _____ Room _____

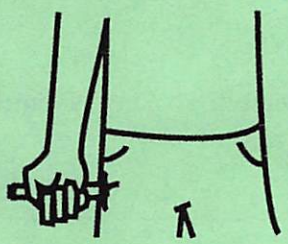
2. _____ Room _____

3. _____ Room _____

EpiPen® and EpiPen® Jr. Directions

- **Pull off gray activation cap.**

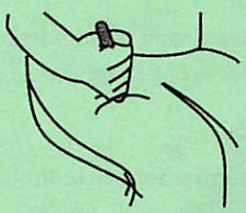
- **Hold black tip near outer thigh (always apply to thigh).**



- **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.**

Twinject™ 0.3 mg and Twinject™ 0.15 mg Directions

- **Pull off green end cap, then red end cap.**

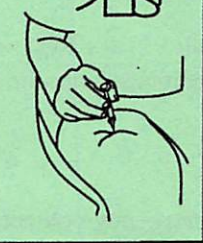


- **Put gray cap against outer thigh, press down firmly until needle penetrates. Hold for ten seconds, then remove.**

SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

- **Unscrew gray cap and remove syringe from barrel by holding blue collar at needle base.**

- **Slide yellow or orange collar off plunger.**



- **Put needle into thigh through skin, push plunger down all the way, and remove.**

Once EpiPen® or Twinject™ is used, call the Rescue Squad. Take the used unit with you to the Emergency Room. Plan to stay for observation at the Emergency Room for at least 4 hours.

For children with multiple food allergies, consider providing separate Action Plans for different foods.

***Medication checklist adapted from the Authorization of Emergency Treatment form developed by the Mount Sinai School of Medicine. Used with permission.*

The Food Allergy & Anaphylaxis Network

Food Allergy Action Plan

Place Child's Picture Here

Student's Name:_____ **D.O.B:**_____ **Teacher:** _____

ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:		**Give Checked Medication**:**
▪ If a food allergen has been ingested, but *no symptoms*:		☐ Epinephrine ☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat†	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung†	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart†	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other†	_____	☐ Epinephrine ☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give:		☐ Epinephrine ☐ Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg
(see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.)_____
c. _____	1.)_____	2.) _____

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED,
DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)