NYC Health | Department of Health and Mental Hygiene | Department of Education

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth *(Month/Day/Year)* ___/___/______

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______

City/Borough | State | Zip Code | School/Center/Camp Name | District Number ___ | Phone Numbers Home ______ Cell ______ Work ______

Health Insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*
☐ Uncomplicated ☐ Premature: ______ weeks gestation
☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed
☐ Drugs *(list)* ______
☐ Foods *(list)* ______
☐ Other *(list)* ______

Attach MAF if in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF)*: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None
Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***
☐ None ☐ Yes *(list below)*

PHYSICAL EXAM Date of Exam: ___/___/___

Height ______ cm (____ %ile)
Weight ______ kg (____ %ile)
BMI ______ kg/m² (____ %ile)
Head Circumference *(age ≤2 yrs)* ______ cm (____ %ile)
Blood Pressure *(age ≥3 yrs)* ______ / ______

General Appearance:

☐ Physical Exam WNL

Nl Abnl	Nl Abnl	Nl Abnl	Nl Abnl	Nl Abnl
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*
Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___
Screening Results: ☐ WNL
☐ Delay or Concern Suspected/Confirmed (specify area(s) below):
☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ______
Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition
< 1 year ☐ Breastfed ☐ Formula ☐ Both
≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred
Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___ ___/___/___	______ μg/dL ______ μg/dL
Lead Risk Assessment *(at each well child exam, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
— **Child Care Only** —		
Hemoglobin or Hematocrit	___/___/___	______ g/dL ______ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*
OAE	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐ *Nl* ☐ *Abnl* ☐ *Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental	
Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐ Physician Confirmed History of Varicella Infection ☐ Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Td	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Polio	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Hep B	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Hib	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
PCV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Influenza	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
HPV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	

Tdap	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__	__/__/__
Mening ACWY	__/__/__	__/__/__	__/__/__
Hep A	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__
Mening B	__/__/__	__/__/__	__/__/__
Other ______	__/__/__	______	__/__/__

IgG Titers	Date
Hepatitis B	__/__/__
Measles	__/__/__
Mumps	__/__/__
Rubella	__/__/__
Varicella	__/__/__
Polio 1	__/__/__
Polio 2	__/__/__
Polio 3	__/__/__

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

RECOMMENDATIONS ☐ Full physical activity
☐ Restrictions *(specify)* ______
Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: __/__/__
Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision
☐ Other ______

Health Care Practitioner Signature | Date Form Completed ___/___/___ | **DOHMH ONLY** **PRACTITIONER I.D.** ☐☐☐☐☐☐☐

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State | **TYPE OF EXAM:** ☐ NAE Current ☐ NAE Prior Year(s)
Comments:

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip | Date Reviewed: ___/___/___ **I.D. NUMBER** ☐☐☐☐☐☐☐ REVIEWER:

Telephone | Fax | Email | **FORM ID#** ☐☐☐☐☐☐☐☐☐☐

CENTER NAME:

ADDRESS:

BORO:

318K (REV. 8/02)

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF DAY CARE

DAY CARE CUMULATIVE HEALTH RECORD

Date of Admission ____/____/____

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

NAME: (Last) (First) (Middle)		SEX F ☐ M ☐	DATE OF BIRTH Country/State of Birth
ADDRESS: (No.) (Street) (City/Boro) (State) (Zip)			
MOTHER'S NAME: (First) (Last)	FATHER'S NAME: (First) (Last)		TELEPHONE NO Home: Work:
FOSTER PARENT			
FOSTER AGENCY	ADDRESS		TELEPHONE #
LANGUAGE SPOKEN IN HOME			

PERSON/S TO CONTACT IN CASE OF EMERGENCY *(Other Than Parent)*	
NAME	RELATIONSHIP TO CHILD
ADDRESS	TELEPHONE NO. Home: Work:

NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL

NAME	CONTACT PERSON	PATIENT NO.
ADDRESS		TELEPHONE NO.

SIGNIFICANT FAMILY HISTORY		IS CHILD ALLERGIC TO ANY:
(____) Sickle Cell	(____) Heart Disease	(____) Medications *(Specify)*
(____) Diabetes	(____) Hypertension	(____) None
(____) Convulsive Disorder	(____) Tuberculosis	(____) Foods *(Specify)*
(____) Allergies *(Specify)*	(____) Vision	(____) Insect Bites
(____) OTHER *(Specify)*	(____) Hearing	(____) OTHER

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN
Has child ever been hospitalized or operated on?			
Has child ever had a serious accident (broken bone, head injury, fall, burns, poisoning)?			
Has child ever had a serious illness?			

SPECIAL HEALTH CONDITIONS	AGE IT BEGAN	TREATMENT/MEDICATIONS
(Long term or chronic)		
1.		
2.		
3.		
4.		
5.		

I, _____ hereby certify that information provided herein is complete and accurate.

CONSENT FOR EMERGENCY MEDICAL TREATMENT *(REQUIRED FOR ADMISSION TO DAY CARE)*

I do hereby give authority to the day care program staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

SIGNED _____ DATE _____ RELATIONSHIP _____

Subscribed and sworn to before me this _____ day of _____ 19 _____

_____ _____

Notary Public or Commissioner of Deeds (OPTIONAL) County of

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

FAMILY DAY CARE AND GROUP FAMILY DAY CARE PROGRAM SLEEPING AND NAPPING AGREEMENT

This form may be used to meet the regulatory requirement that, other than for school-age children, sleeping and napping arrangements must be made in writing between the parent and the program.

Name of Child in Care:	**Date of Birth** / /

Name of Parent/Guardian:	
Name of Program/Provider:	Facility ID#

Napping Agreements:

Area of home where child will nap:
Sleeping arrangements (Check all that apply): ☐ Mat ☐ Cot ☐ Bed ☐ Crib
How will the child be supervised? ☐ Direct supervision ☐ Functional electronic monitor (provider must remain on same floor and physically check on child every 15 minutes)

Evening and Night Sleeping Agreements:

Area of home where child will sleep:
Sleeping surface (Check all that apply): ☐ Mat ☐ Cot ☐ Bed ☐ Crib
How will the child be supervised? ☐ Direct supervision (provider must remain awake and physically check on sleeping child every 15 minutes) ☐ Functional electronic monitor in room where child is sleeping (provider may sleep while child is sleeping)

All applicable regulations must be followed, including, but not limited to, those listed below. Contact your regulator with any questions.

- Sleeping arrangements for infants through 12 months of age require that the infant be placed flat on their back to sleep, unless medical information from the child's health care provider is presented to the program by the parent that shows that arrangement is inappropriate for that child.
- Cribs, bassinets, and other sleeping areas for infants through 12 months of age must include an appropriately sized fitted sheet and must not have bumper pads, toys, stuffed animals, blankets, pillows, wedges, or infant positioners. Wedges or infant positioners will be permitted with medical documentation from the child's health care provider.
- The resting/napping places must be located in approved day care space; be located in safe areas of the home; be located in a draft-free area; be where children will not be stepped on; be in a location where safe egress is not blocked; and allow caregivers to move freely and safely within the napping area in order to check on or meet the needs of children.
- Children unable to sleep during nap time shall not be confined to a sleeping surface (cot, crib, etc.) but instead must be offered a supervised place for quiet play.

OCFS-LDSS-0792 (10/2018) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

Child's Full Name: Preferred Name/Nickname:	Date of Birth: / /	Gender:
Child's Home Address:		
Name of Person Enrolling Child:	Relationship to Child: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ____ ☐ Other ____	
Phone Number(s) of Person Enrolling Child: ( ) - ☐ ok to text **Email Address:**	Address of Person Enrolling Child (if different than child):	

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
Primary Contact:	☐ Yes ☐ No	☐ ok to text	☐ ok to text
	☐ Yes ☐ No	☐ ok to text	☐ ok to text
	☐ Yes ☐ No	☐ ok to text	☐ ok to text

For Program Use Only Date of Enrollment: / /	*For Program Use Only* Date of Disenrollment: / /

OCFS-LDSS-0792 (10/2018) REVERSE

Child's Full Name:	Date of Birth: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (list) _____

☐ Other _____

Please provide information here **AND** discuss with your child care provider:

Child's Primary Care Physician's Name/ Group:	Phone Number: ( ) -
Preferred Hospital:	Phone Number: ( ) -
Child's Dental Care:	Phone Number: ( ) -

Child health insurance information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child..... ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision..... ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips..... ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child..... ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation..... ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year..... ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

OCFS-6010 (5/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellant.
- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:

7A. Frequency to be administered, include times of day if appropriate: _____

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____

8A. Possible side effects: ☐ See product label for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects:

9. What action should the child care provider take if side effects are noted:

☐ Contact parent _____

Other (describe): _____

10A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: _____

11. Reason(s) for use (unless confidential by law): _____

12. Parent name (please print):	13. Date authorized:

14. Parent signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)

15. Program name:	16. Facility ID number:	17. Program telephone number:

18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff's name (please print):	20. Date received from parent:

21. Staff's signature:

X

Date of Plan: / /

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- **Inject epinephrine immediately and note the time when the first dose is given.**
- **Call 911/local rescue squad** (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored:

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

***Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area.

Explain here:

AUTHORIZATION TO PICK UP A CHILD FROM THE CHILDREN'S CENTER

Name of Child(ren): _____

I hereby inform The Children's Center that the people listed below are authorized to pick up the above named child(ren) at anytime. Accordingly, The Children's Center is hereby instructed to release my child(ren) into the care of the following people whenever they come to The Children's Center.

AUTHORIZED PICK-UP PERSON:

	Name:	Relationship to Child:	Phone Number:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I understand that:

- Parents/guardians must inform The Children's Center (call, leave a note at drop off) of the name of the person who is picking up their child on any day when they themselves are not.
- The "Authorized Pick-Up Person" ***must be at least 18 years old*** and may be asked to provide a photo ID to the staff.
- This authorization shall remain in force until edited or rescinded in writing by the signers of this authorization.

Authorized by:

_____ _____

Parent/Guardian Signature *Date*

_____ _____

Parent/Guardian Signature *Date*

Feeding Schedule

FOR _____, DOB: _____,
(Child's Name)

I _____
(Parent's Name)

☐ Will Supply _____, with _____ bottles of prepared
(Provider's Name)

_____ formula, to be fed _____ times a day.
(Name of Formula)

☐ Give permission to the On-Site Provider to prepare _____
(Name of Formula)

formula, for _____ bottles per day, to be fed _____ times a day.

☐ Will also provide:

_____ Bottle/s of water, to be fed _____ times a day,
_____ Bottle/s of juice, to be fed _____ times a day,
_____ Yogurt, to be fed _____ times a day,
_____ Puree fruit, to be fed _____ times a day,
_____ Cereal, to be fed _____ times a day by spoon.

Additional Notes:

_____

_____

_____

_____

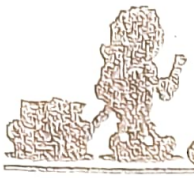
_____

Parent's Signature:

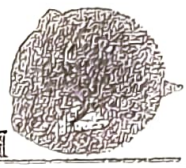
Signature: _____ Date: _____

- With the prior written permission of the parent, children who are napping or sleeping may do so in a room where an awake, approved caregiver is not present, but the doors to all rooms must be open; the approved caregiver must remain on the same floor as the children; and a functioning electronic monitor must be used in any room where children are sleeping or napping and an awake, approved caregiver is not present.
- When a functioning electronic monitor is in use, napping and sleeping children must be physically checked every 15 minutes to assess the overall safety and well-being of the children and to make sure infants' faces are uncovered. The checks must be done in close physical proximity to the child.
- For evening and night care, the caregiver may sleep while children are sleeping only if functional electronic monitors are in use in each room where children are sleeping. The licensee must obtain the written permission to do so from the parent of each child receiving evening or night care in the home. In the event written permission is not obtained from all parents, the caregiver must remain awake at all times and physically check sleeping children every 15 minutes to assess the overall safety and well-being of the children and to make sure infants' faces are uncovered. The checks must be done in close physical proximity to the child.
- A copy of this agreement must be kept on file at the program and accessible for review.

Signature of Parent/Guardian	Signature of Provider
/ /	/ /
Date	Date



OUT DOOR ACTIVITY PERMISSION FORM



The provider and staff

of_____ may take my

child _____for short walking

trips and any of the activities checked below as

part of the Family/Group Family Day Care

Program.

( ) Providers' back yard

( ) Neighborhood Park

( ) Other _____

Parent/Guardian (print)

_____Date__/__/__

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

Child's Name: Date of Plan: / /
Date of Birth: / / Current Weight: lbs.
Asthma: ☐ Yes (higher risk for reaction) ☐ No

My child is reactive to the following allergens:

Allergen:	**Type of Exposure:** (*i.e., air/skin contact/ingestion, etc.*):	**Symptoms Include but are not limited to:** (*check all that apply*)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)

If my child was LIKELY exposed to an allergen, for ANY symptoms:
☐ give epinephrine immediately

If my child was DEFINITELY exposed to an allergen, even if no symptoms are present:
☐ give epinephrine immediately