## YMCA of Greater Seattle Allergy Plan



Plan must be updated annually or when there is a change in the child's accommodation or care needs.

TIVICA ALLERGY PLAN
Thank you for filling out this form to help us best serve your child in our Y programs. Please fill out the sections required for your child's allergy.
Please keep in mind that some sections may not apply to your child's needs, feel free to leave these blank.
If you have any questions regarding this form, please reach out to our Youth Program Support team at <a href="mailto:youthsupport@seattleymca.org">youthsupport@seattleymca.org</a>
Section 1: General Information
Section 2: Required for Medication Allergies, Food Allergies, or Special Dietary Requirements
Section 3: Required for Environmental Allergies

SECTION 1 – REQUIRED			
Child's Full Name	Today's Date		
Parent's/Guardian's Name	Phone Number		
Primary Health Care Provider	Phone Number		
Specialist (if applicable)	Phone Number		
Specialist (if applicable)	Phone Number		

## **PLEASE CONTINUE TO PAGE 2**

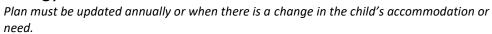
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SECTION 2 – REQUIRED FOR MEDICATION OR FOOD ALLERGIES OR SPECIAL DIETARY REQUIREMENT				
MEDICATION AND FOOD ALLERGY/SPECIAL DIETARY REQUIREMENTS				
This page must be completed and signed by the child's	health care provider and	parent or guardian		
Child's Full Name		Today's Date		
Food the child must not consume (list each food separately)	Appropriate substitute f	ood(s)		
. , , , ,				
Describe the reaction and symptoms associated with thi	s child's particular allergie	s:		
Describe the treatment plan for the provider to follow in response to the child's allergic reaction, include names of medications, dosage amounts, and directions for how to administer medication. (Medical Authorization Form must be completed for each medication provided during program hours for both regular and emergency administered medication):				
Other dietary requirements due to health condition:				
Health Care providers Signature (required)	[	Date		
Parent or Guardian Signature				
	С	Date		

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SECTION 3 – REQUIRED FOR EVIRONMENTAL ALLERGIES				
ENVIRONMENTA	AL REQUIREMENTS			
Child's Full Name	Today's Date			
	•			
Environmental Allergy	Reaction and Symptoms			
Describe the treatment plan for the provider to follow in response to the child's allergic reaction. (Medical Authorization Form must be completed for each medication provided during camp hours for both regular and emergency administered medication):				
Other dietary requirements due to health condition:				
Health Care providers Signature (optional)		Date		
SIGNATURE				
Parent or Guardian Signature		Date		
Y Staff Signature		Date		
This section to be completed by child's parent or guardian, if applicable:				
I hereby give permission for to provide services to my child at this program.  (name of visiting health professional or specialist)				
Parent or Guardian Signature		Date		