04 Health procedures

**04.4 Allergies and food intolerance**

When a child starts at the setting, parents are asked if their child has any known allergies or food intolerance. This information is recorded on the registration form.

* If a child has an allergy or food intolerance, 01.1a Generic risk assessment form is completed with the following information:
* the risk identified – the allergen (i.e. the substance, material or living creature the child is allergic to such as nuts, eggs, bee stings, cats etc.)
* the level of risk, taking into consideration the likelihood of the child coming into contact with the allergen
* control measures, such as prevention from contact with the allergen
* review measures
* 0**4.2a Health care plan form** must be completed with:
* the nature of the reaction e.g. anaphylactic shock reaction, including rash, reddening of skin, swelling, breathing problems etc.
* managing allergic reactions, medication used and method (e.g. Epipen)
* The child’s name is added to the Dietary Requirements list**.**
* A copy of the risk assessment and health care plan is kept in the child’s personal file and is shared with all staff.
* Parents show staff how to administer medication in the event of an allergic reaction.
* Generally, no nuts or nut products are used within the setting.
* Parents are made aware, so that no nut or nut products are accidentally brought in.
* Any foods containing food allergens are identified.

#### Oral Medication

* Oral medication must be prescribed or have manufacturer’s instructions written on them.
* Staff must be provided with clear written instructions for administering such medication.
* All risk assessment procedures are adhered to for the correct storage and administration of the medication.
* The setting must have the parents’ prior written consent. Consent is kept on file.

For other life-saving medication and invasive treatments please refer to 04.2 Administration of medicine.

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| **Policy:** | 04.4 Allergies and food intolerance |
| This policy was reviewed on: |  |
| Date to be reviewed: |  |
| **Signed on behalf of the provider:** |  |
| Name of signatory: |  |
| Role of signatory: |  |

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