



Karen's Castle Day School Inc.
81 Glenwood Road
Glen Head, NY 11545
(516) 674 – 3834
KarenGreene@karencastle.com
www.karencastle.com



The following are the Agreement Forms between (parent's name) _____ and Karen's Castle Inc. for the childcare to be provided for (child's name) _____.

Child's/Children's Start Date: _____

- If a parent is late in picking up, there is a **\$25 late charge for every 15 minutes you are late**. For example, if the pick up time is 5pm, the late charge starts accruing at 5:01pm. ***Please note that payment of late fee is due the day you are late.** If you are going to be late, please call at least 1 hour prior to pick up.
 - Please email the night before or call the morning of, if your child is not coming to school.
 - **NOTE: There are no make-ups or refunds for days that your child is absent. There are no make ups or refunds for the days school is closed.**

The following people are authorized to pick up my child at Karen's Castle:
 (Please provide a copy of the authorized person's drivers license or passport)

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

Payments:

- All children's schedules are prepaid monthly.
- Tuition is **due on or before the 10th** for each upcoming month.
- Venmo Karen-Greene-4, Cash or check made payable to Karen's Castle Inc.
- There is a \$50 late charge (accruing on the 11th of the month) for payments 1-4 days late, and \$100 late charge for payments 5-9 days late.

Bounced Check Policy:

- There is a \$50 bounced check fee and all future payments will be restricted to cash or Venmo.



The length of this contract:

*10 and 12 month programs are available.
(Please see the attached Calendar to see exact start and end dates.)

The contract can be changed or terminated by either party with one month's notice. Karen's Castle does reserve the right to expel a child immediately if their behavior is inappropriate or harmful to the other students. No refund would be given.

I give permission to Karen's Castle Inc. and staff to apply sun block on my child. I understand that I must apply the sun block before my child attends Karen's Castle. I will supply the sun block for Karen's Castle and staff to re-apply. I will label the sunblock with my child's first & last name.

I give permission for my child to sleep in the classroom or on the first floor on a mat. I understand the door of the room will be open and supervision will be provided on the same floor. I will provide a blanket and sheet for my child's use.

I give my permission for my child's picture to be used for promotional purposes and our website.

I give permission to Karen's Castle and staff to transport my child in his/her car.

My staff and I are NYS mandated reporters of child abuse and maltreatment. If you suspect child abuse or neglect the hotline is 1-800-342-3720.

***** ALLERGY & CHOKING HAZARD ALERT! *****

The following items are **NOT** allowed in school. There are **NO** exceptions.

- Peanuts
- Tree Nuts
- Coconuts
- Poppy Seeds
- Sesame Seeds
- Eggs
- Avocados
- Shrimp
- Marshmallow
- Candy
- Celery
- Hard Carrots
- Small tomatoes
- Raisins
- Yogurt Covered Raisins
- Popcorn
- Grapes

If an item says that it's made in a nut factory, **DON'T** send it. If it says may contain nuts, **DON'T** send it

I have read this Agreement carefully and with full understanding of the policies of Karen's Castle Inc., I agree to all of the above.

Print Parent's Name

Parent's Signature

Date

Permission to Administer Over-The-Counter Topical Ointments

Please circle “yes” or “no” for the ointments that you are giving permission for Karen’s Castle and staff to apply on your child. A parent must supply the ointment in its original container/box and the directions must be legible.

You must write your child’s first and last name on the medicine.

Please do not cover up the directions.

Please do not leave any ointments or medicine in your child’s backpack.

Please hand them to one of our staff members.

YES	NO	INSECT REPELLANT
YES	NO	SUNSCREEN
YES	NO	FIRST AID CREAM/SPRAY
YES	NO	TRIPLE ANTIBIOTIC OINTMENT
YES	NO	ANTISEPTIC CREAM/SPRAY
YES	NO	BEE STING PADS
YES	NO	DIAPER CREAM
YES	NO	BURN CREAM
YES	NO	OTHER CREAM/OINTMENT (OCT ONLY)

I, _____ give permission to Karen’s Castle Inc. and staff to apply
(Print parent’s full name)
topical over-the-counter medications to my child, _____ according to
(Print child’s full name)
label directions. This permission is in effect while my child attends Karen’s Castle.

Parent’s Signature

Date

TO BE NOTARIZED

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I, _____, the parent of _____
(Full Name of Parent) (Full Name of Child/Children)
authorize Karen Greene and Staff to obtain medical care for my child in case of emergency. My permission is given to any hospital or doctor to treat my child in case of emergency. Permission for treatment will only be given if I cannot be contacted or if immediate treatment is warranted at the discretion of the attending medical person.

Signed: _____
(Parent/Legal Guardian)

Date: _____

NOTARY SEAL: _____

NAME OF INSURED: _____

NAME OF INSURANCE COMPANY: _____

POLICY #: _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD.
(FRONT AND BACK)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)	PROGRAM NAME:		ADDRESS:		PHONE NUMBER: () -	
	CHILD'S FULL NAME:				DATE OF BIRTH: / /	
	PREFERRED NAME/NICKNAME:				GENDER:	
	CHILD'S HOME ADDRESS:					
NAME OF PERSON ENROLLING CHILD:			RELATIONSHIP TO CHILD: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____			
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: () - <input type="checkbox"/> ok to text			ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):			
EMAIL ADDRESS:						
EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES		Authorized to Pick Up Child	PRIMARY PHONE NUMBER		OTHER PHONE NUMBER / EMAIL
	PRIMARY CONTACT:		<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text		() - <input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text		() - <input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	() - <input type="checkbox"/> ok to text		() - <input type="checkbox"/> ok to text
FOR PROGRAM USE ONLY			FOR PROGRAM USE ONLY			
DATE OF ENROLLMENT: / /			DATE OF DISENROLLMENT: / /			

CHILD'S FULL NAME:		DATE OF BIRTH: / /	
Check boxes below to indicate if your child has any special needs/services: <input type="checkbox"/> None <input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (Please list) _____ <input type="checkbox"/> 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 care 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.....			<input type="checkbox"/> Yes <input type="checkbox"/> 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.....			<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.....			<input type="checkbox"/> Yes <input type="checkbox"/> No
• I provided information on my child's special needs to the program to assist in caring for my child.....			<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.....			<input type="checkbox"/> Yes <input type="checkbox"/> No
• I agree to review and update this information whenever a change occurs and at least once every year.....			<input type="checkbox"/> Yes <input type="checkbox"/> No
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:			DATE: / /

**CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS
HEALTH SCREENING ONE-TIME ATTESTATION**

Before entering a child care program, employees, volunteers, parents, children and essential visitors **must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time.** Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers “Yes” to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are “Yes,” individuals **cannot** enter the program. If the answers are “No” to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer “No” to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing ANY of the following symptoms?
 - Cough (new or worsening)
 - Shortness of breath (new or worsening)
 - Trouble breathing (new or worsening)
 - Fever
 - Chills
 - Muscle pain (new or worsening)
 - Headache (new or worsening)
 - Sore throat (new or worsening)
 - New loss of taste
 - New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered “NO” to all questions, you have passed and may enter the program.

If you have answered “YES” to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

Signature	/ /
Signature	/ /

Note: This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.

Both Parents Must Sign

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:
----------------	----------------	----------------------

Immunizations required for entry into day care

Yes No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus influenzae type B (Hib)	1 st Date	2 nd Date	3 rd Date	4 th Date OR 1 st Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	2 nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: ___ / ___ / ___ Mantoux Results: Positive Negative _____ mm
 TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.
 If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: ___ / ___ / ___
 Attach lead level statement
Lead Screening (Include All Dates and Results)
 1 year ___ / ___ / ___ Result: _____ mcg/dL Venous Capillary
 2 years ___ / ___ / ___ Result: _____ mcg/dL Venous Capillary
Most recent date of lead screening (if different from above):
 ___ / ___ / ___ Result: _____ mcg/dL Venous Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely.
 If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics

Comments

Are there allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care.

Yes No

Signature of Examiner	Address
Please Print Name	City, State, Zip
Title	() Phone
	Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

EMERGENCY NUMBERS

Child/Children's Name: _____

Mom's Full Name: _____

Work # (include ext.): _____

Cell Phone #: _____

Home #: _____

Address: _____

Email: _____

Dad's Full Name: _____

Work # (include ext.): _____

Cell Phone #: _____

Home #: _____

Address: _____

Email: _____

Emergency Contact (1)

Full Name & Number: _____

Emergency Contact (2)

Full Name & Number: _____

Pediatrician

Full Name & Number: _____

Dentist

Full Name & Number: _____

Child/Children's Birthday: _____

Allergies/Special Medical Needs: _____

How Did You First Hear About Karen's Castle? _____

Please print clearly. Fill out every space. Fill in N/A when appropriate.

Please do not forget the area code.

Supply List:

Please provide the following supplies:

- Backpack large enough to hold the following items:
- Soft Lunchbox (we recommend Packit Lunchboxes)
- 1 Plastic Folder with Pockets (to be left in backpack)
- **A full change of clothes, head to toe including shoes** (please keep in your child's backpack at all times)

For Nappers:

- Crib Sheet
- Blanket for Napping

For Students in Diapers or Pull-ups:

- A Box of Wipes
- Diapers/Pull-ups (Child's first name on each diaper/pull-up)

For Half-Day AM (8:25 AM – 12:20 PM) & Full Day (8:25 AM – 2:25 PM):

- Please pack a non-spillable water bottle, a healthy lunch with utensils and napkins

For Half-Day PM (12:30 – 4:30):

- Please pack a healthy snack with utensils, napkins & a non-spillable water bottle.

For Extended Day (8:30 AM – 4:30 PM)

- Please pack a non-spillable water bottle, a healthy snack & a healthy lunch with utensils and napkins

For After-School Students:

- Please pack a healthy snack with utensils, napkins & a non-spillable water bottle

Please write your child's first and last name on their water bottle and ALL containers

Karen's Castle References

Karen & John Rebecchi
Student: Jackson
(845) 642 – 4509

Cheryl & Rob Brown
Student: Thomas
(631) 885 – 0199

Kristen & Christian Wagner
Students: Maddie & Emma
(516) 671 – 0721

Michaela & John Morales
Students: Aubrey & Ronan
(516) 532 – 4789

Jack & Linda Yao
Students: Preston & Kendall
Dad: (646) 261-6566
Mom: (917) 574- 2233

Diana & Edward Rhodes
Students: Lexi & Richie
(516) 671 – 5740

Steve & Jenn Hausel
Student: Sabrina
(516) 801 – 1228





Karen's Castle Day School

2021-2022 School Calendar



September 2021						
Su	M	Tu	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

October 2021						
Su	M	Tu	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

November 2021						
Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

December 2021						
Su	M	Tu	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

January 2022						
Su	M	Tu	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

February 2022						
Su	M	Tu	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28					

March 2022						
Su	M	Tu	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

April 2022						
Su	M	Tu	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

May 2022						
Su	M	Tu	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

June 2022						
Su	M	Tu	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

July 2022						
Su	M	Tu	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

August 2022						
Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	1	2	

2021

September 6th – School Closed
 September 7th – 1st Day of School
 October 11th – School Closed
 November 11th – School Closed
 November 25th & 26th – School Closed
 December 24th-28th – School Closed
 December 31st – School Closed

2022

January 17th – School Closed
 February 21st – School Closed
 April 15th-18th – School Closed
 May 30th – School Closed
 June 24th – Last Day of School

Summer Camp 2022

June 27th – Camp Starts
 July 4th – Camp Closed
 Sept. 2nd – Last Day of Camp

ALLERGY & CHOKING HAZARD ALERT!

The following items are **NOT** allowed in school.
There are **NO** exceptions.

- Peanuts
- Tree Nuts
- Coconuts
- Poppy Seeds
- Sesame Seeds
- Eggs
- Avocados
- Shrimp
- Marshmallow
- Candy
- Celery
- Hard Carrots
- Small Tomatoes
- Raisins
- Yogurt Covered Raisins
- Popcorn
- Grapes

If an item says that it's made in a nut factory, **DON'T** send it.

If it says may contain nuts, **DON'T** send it.

Thank you 😊

GUIDELINES FOR EXCLUSION OF SICK CHILDREN FROM CHILD CARE

1. Signs of possible moderate or severe illness: unusual lethargy, irritability, persistent crying, difficulty breathing, and/or inability to function in a group setting.
2. A child exhibiting fever of >100°F axillary or >101°F orally should be excluded for a minimum of 24 hours.
3. Persistent, frequent cough that interferes with the child's activities.
4. Diarrhea defined as an increase in the number of stools, compared with the child's normal pattern with increased stool water and/or decreased form (diarrhea that cannot be contained within diapers or toilet use).
5. Effortful vomiting, unless the vomiting is determined to be non-disease related and the child is not in danger of dehydration.
6. Rash with fever or behavior change; or a rash that is possibly infectious.
7. Chicken pox – 6 days after onset of rash or until all lesions have dried and crusted. Children who receive the chicken pox vaccine should not be excluded unless they develop a rash. Rashes can develop up to 6 weeks after a child receives the vaccine. Rashes from the vaccine usually disappear sooner (within 1-2 days).
8. Strep throat/scarlet fever – until 24hrs. after treatment has been initiated.
9. Impetigo – until 24hrs after treatment has been initiated.
10. Ringworm (head, body, genitals, or feet infection) until 24hrs. after treatment has been initiated.
11. Scabies/head lice – allowed to return to child care the morning after their first treatment.
12. Purulent conjunctivitis (“pink eye”) – defined as pink or red conjunctiva with white or yellow eye discharge, often with matted eyelid after sleep; including a child with eye pain or redness or the eyelid or skin surrounding the eye – until 24hrs. after treatment has been initiated.
13. Mouth sores associated with an inability of the child to control his/her saliva.
14. Failure to comply with New York State Immunization Laws.
15. **A doctor's note is required to clear and permit the child to return to school.**



Tips for Avoiding Your Allergen

- All FDA-regulated manufactured food products that contain a “major food allergen” (milk, wheat, egg, peanuts, tree nuts, fish, crustacean shellfish, and soy) as an ingredient are required by U.S. law to list that allergen on the product label. For tree nuts, fish and crustacean shellfish, the specific type of nut or fish must be listed.
- Read all product labels carefully before purchasing and consuming any item.
- Be aware of unexpected sources of allergens, such as the ingredients listed below.
- *Note: This list does not imply that the allergen is always present in these foods; it is intended to serve as a reminder to always read the label and ask questions about ingredients.



For a Peanut-Free Diet

Avoid foods that contain peanuts or any of these ingredients:

artificial nuts	goobers	nut meat
beer nuts	ground nuts	peanut butter
cold pressed, expeller pressed, or extruded peanut oil	mixed nuts	peanut flour
	monkey nuts	peanut protein hydrolysate
	nut pieces	

Peanut is sometimes found in the following:

African, Asian (especially Chinese, Indian, Indonesian, Thai, and Vietnamese), and Mexican dishes	baked goods (e.g., pastries, cookies) candy (including chocolate candy) chili egg rolls	enchilada sauce marzipan mole sauce nougat
---	---	--

Keep the following in mind:

- Mandelonas are peanuts soaked in almond flavoring.
- The FDA exempts highly refined peanut oil from being labeled as an allergen. Studies show that most allergic individuals can safely eat peanut oil that has been highly refined (not cold pressed, expeller pressed, or extruded peanut oil). Follow your doctor's advice.
- A study showed that unlike other legumes, there is a strong possibility of cross-reaction between peanuts and lupine.
- Arachis oil is peanut oil.
- Many experts advise patients allergic to peanuts to avoid tree nuts as well.
- Sunflower seeds are often produced on equipment shared with peanuts.
- Some alternative nut butters, such as soy nut butter or sunflower seed butter, are produced on equipment shared with other tree nuts and, in some cases, peanuts. Contact the manufacturer before eating these products.



For a Tree-Nut-Free Diet

Avoid foods that contain nuts or any of these ingredients:

almond	hickory nut	nut pieces
artificial nuts	litchi/lychee/lychee nut	pecan
beechnut	macadamia nut	pesto
Brazil nut	marzipan/almond paste	pili nut
butternut	Nangai nut	pine nut (also referred to as Indian, pignoli, pignolia, pignon, piñon, and pinyon nut)
cashew	natural nut extract (e.g., almond, walnut)	nut butters (e.g., cashew butter)
chestnut	nut meal	pistachio
chinquapin nut	nut meat	praline
coconut*	nut paste (e.g., almond paste)	shea nut
filbert/hazelnut		walnut
gianduja (a chocolate-nut mixture)		
ginkgo nut		

Tree nuts are sometimes found in the following:

black walnut hull extract (flavoring)	nut distillates/alcoholic extracts	walnut hull extract (flavoring)
natural nut extract	nut oils (e.g., walnut oil, almond oil)	

Keep the following in mind:

- Mortadella may contain pistachios.
- There is no evidence that coconut oil and shea nut oil/butter are allergenic.
- Many experts advise patients allergic to tree nuts to avoid peanuts as well.
- Talk to your doctor if you find other nuts not listed here.
- * Coconut, the seed of a drupaceous fruit, has typically not been restricted in the diets of people with tree nut allergy. However, in October of 2006, the FDA began identifying coconut as a tree nut. Medical literature documents a small number of allergic reactions to coconut; most occurred in people who were not allergic to other tree nuts. Ask your doctor if you need to avoid coconut.



For an Egg-Free Diet

Avoid foods that contain eggs or any of these ingredients:

albumin (also spelled albumen)	livetin	vitellin
egg (dried, powdered, solids, white, yolk)	lysozyme	words starting with "ovo" or "ova" (such as ovalbumin)
eggnog	mayonnaise	
globulin	meringue (meringue powder)	
	surimi	

Egg is sometimes found in the following:

baked goods	fried rice	meatloaf or meatballs
breaded items	ice cream	nougat
drink foam (alcoholic, specialty coffee)	lecithin	pasta
egg substitutes	marzipan	
	marshmallows	

Keep the following in mind:

- Individuals with egg allergy should also avoid eggs from duck, turkey, goose, quail, etc., as these are known to be cross-reactive with chicken egg.
- While the whites of an egg contain the allergenic proteins, patients with an egg allergy must avoid all eggs completely.