Karen's Castle Day School Inc.
81 Glenwood Road
Glen Head, NY 11545
(516) 674 – 3834
KarenGreene@karenscastle.com
www.karenscastle.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, Zelle, 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
- Humus
- Shrimp
- Dairy
- Marshmallow
- Candy
- Celery
- Hard Carrots
- Small tomatoes
- Raisins
- Yogurt Covered Raisins
- Popcorn
- Grapes

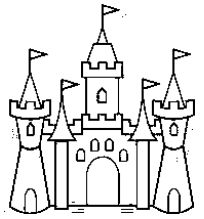
If an item says that it's made in a nut factory, **DON'T** send it. If it says may contain nuts, **DON'T** send it

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**

Karen's Castle Day School Registration
Nursery & Pre-K Programs Registration Form



Child's Full Name: _____

Please put an X on the days you would like to register your child.
Leave the other boxes blank.

Please Circle the year your child will be entering Kindergarten

Year Entering Kindergarten	2023	2024	2025

2 Days Per Week		
Program	**Tue**	**Thu**
Full Day: 8:20 AM – 2:20 PM		
Extended Day: 8:30 AM – 5:00 PM		
Extra Hours	**Tue**	**Thu**
7:30 Drop Off		
8:00 Drop Off		
5:00 Pick Up		
5:30 Pick Up		

3 Days Per Week			
Program	**Mon**	**Wed**	**Fri**
Full Day: 8:20 AM – 2:20 PM			
Extended Day: 8:30 AM – 5:00 PM			
Extra Hours	**Mon**	**Wed**	**Fri**
7:30 Drop Off			
8:00 Drop Off			
5:00 Pick Up			
5:30 Pick Up			

5 Days Per Week					
Program	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**
Full Day: 8:20 AM – 2:20 PM					
Extended Day: 8:30 AM – 5:00 PM					
Extra Hours	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**
7:30 Drop Off					
8:00 Drop Off					
5:00 Pick Up					
5:30 Pick Up					

Parents Full Name (print): _____ **Amount Enclosed: $_____**

Parents Signature: _____ **Date: _____**

Please fill out this form completely and submit with your payment of $250 for the Registration, Materials & Workbook Fees
ALL FEES AND TUITION ARE NON-REFUNDABLE

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 OIINTMENT
YES	**NO**	ANTISEPTIC CREAM/SPRAY
YES	**NO**	BEE STING PADS
YES	**NO**	DIAPER CREAM
YES	**NO**	BURN CREAM
YES	**NO**	Lip Cream/ Chapstick
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**

<u>*TO BE NOTARIZED*</u>

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 #: _____

<u>PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD.</u>
(FRONT AND BACK)

OCFS-LDSS-0792 (08/2019) FRONT

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: 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 Child	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 (08/2019) 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 (Please 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 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 ..... ☐ 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 ..... ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field ..... ☐ Yes ☐ No
- I provided information on my child s special needs to the program to assist in caring for my ..... ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by ..... ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every ..... ☐ Yes ☐ No

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

NEW YOK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

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	Date / /
Signature	Date / /

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)	1st Date	2nd Date	3rd Date	4th Date	5th Date
Polio (IPV or OPV)	1st Date	2nd Date	3rd Date	4th Date	
Haemophilus influenzae type B (Hib)	1st Date	2nd Date	3rd Date	4th Date **OR** 1st Date (if given on or after 15 months of age)	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date	2nd Date	3rd Date	4th Date	
Hepatitis B	1st Date	2nd Date	3rd Date		
Measles, Mumps and Rubella (MMR)	1st Date	2nd Date			
Varicella (also known as Chicken Pox)	1st Date	2nd 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)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ 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: _____

Parent/Guardian Full Name: _____

Work # (include ext.): _____

Cell Phone #: _____

Home #: _____

Address: _____

Email: _____

Parent/Guardian 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
  (Childs first name on each diaper/pull-up)

For Full Day (8:20 AM – 2:20 PM):

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

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

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

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

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

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

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

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

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

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

Tree nuts are sometimes found in the following:

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

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)*
egg *(dried, powdered, solids, white, yolk)*
eggnog
globulin
livetin
lysozyme
mayonnaise
meringue *(meringue powder)*
surimi
vitellin
words starting with “ovo” or “ova” *(such as ovalbumin)*

Egg is sometimes found in the following:

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

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.