FORM

Allergy Health Care Plan

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Allergen	Treatment/Substitution
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Type of allergy transmission/trigger: ☐ Ingestion ☐ Contact ☐ Inhalation

Note: Do Not Depend on Antihistamines or Inhalers to treat a SEVERE reaction. USE EPINEPHRINE.

Extremely Reactive to the Following Foods_____; therefore:

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**

☐ **If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.**

For the following signs of a *mild* allergic reaction administer: _____

_____

☐ **Skin:** Hives: Mild Itch

☐ **Nose:** Itchy, Runny, Sneezing

☐ **Stomach:** Mild Nausea/Discomfort

☐ **Mouth:** Itchy

☐ **Other:** _____

For any of the following signs of a *SEVERE* allergic reaction or a combination of symptoms from different body areas, give EPINEPHRINE and CALL 911. If prescribed and directed, give other medications (antihistamine/inhaler). Lay person flat. *If breathing is difficult or vomiting, place on side, or sit up.*

☐ **Mouth:** Significant Swelling of Tongue and/or Lips

☐ **Heart**: Pale, blue, faint, weak pulse, dizzy

☐ **Throat:** Tight, hoarse, trouble breathing/swallowing

☐ **Lungs:** Short of Breath

☐ **Skin:** Many hives over body, widespread redness

☐ **Stomach:** Repetitive vomiting, severe diarrhea

☐ **Other:** Feeling something bad is about to happen; anxiety, confusion

Other Medication Instructions: _____

_____

Prescribed Medications/Dosage

Epinephrine (brand and dose)**:** _____

Antihistamine (brand and dose)**:** _____

Other (e.g., inhaler-bronchodilator if asthmatic):_____

Potential Side Effects of Medication: _____

_____

Potential Consequences to Child if Treatment is Not Administered: _____

_____

Staff Training

Staff may be trained by: _____

The following staff have been trained on the child's medical condition:

_____ _____

_____ _____

_____ _____

Parent/Guardian Acknowledgement Statement

To ensure the safety of your child we cannot delete an allergy which has previously been documented unless we have a signed note from the child's physician stating that the child is no longer allergic to that item(s) and may now have that specific food(s) ; or be exposed to the item(s); nor can we add an item(s) or change a medication without a signed note from the child's physician.

I understand that Bright Horizons requires the most up to date information regarding my child's allergy. I also understand that for the safety of my child, my child's photograph and allergy information will be posted in the classrooms and kitchen.

_____ _____

Physician Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Director/Principal Signature Date

This plan must be updated annually or whenever there is any change in treatment or the child's condition changes.

For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the Medication Authorization form.