



Allergy Health Care Plan

Name: _____

DOB: _____

Emergency Contact Name: _____

Phone: _____

Physician's Name: _____

Phone: _____

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

Type of allergy transmission: Ingestion Contact Inhalation

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

- Skin: Hives: Mild Itch
- Stomach: Mild Nausea/Discomfort
- Other: _____
- Nose: Itchy, Runny, Sneezing
- Mouth: Itchy

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
- Throat: Tight, hoarse, trouble breathing/swallowing
- Skin: Many hives over body, widespread redness
- Other: Feeling something bad is about to happen; anxiety, confusion
- Heart: Pale, blue, faint, weak pulse, dizzy
- Lungs: Short of Breath
- Stomach: Repetitive vomiting, severe diarrhea

Other Medication Instructions: _____

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.



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: _____

_____ Physician Signature	_____ Date
_____ Signature	_____ Date
_____ Director/Principal Signature	_____ Date

Acknowledgment Statement

To ensure your safety we cannot delete an allergy which has previously been documented unless we have a signed note from your physician stating that you are 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 your physician.

I understand that Bright Horizons requires the most up to date information regarding my allergy. I also understand that for my safety a photograph and allergy information will be posted in the kitchen.

Signature

Date

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

*For complete medication administration information, it may be necessary for the medical provider to complete the Medication Authorization form.