Bright Horizons FAMILY SOLUTIONS®

FORM

Allergy Health Care Plan

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

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

Type of allergy transmission: ☐ 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: _____

_____

For MA and MN centers only:

Staff may be trained by: _____

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

_____ _____

_____ _____

_____ _____

_____ _____
Physician Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Director/Principal Signature Date

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.

_____ _____
Parent/Guardian Signature Date

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

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