

# 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 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.***