

This form is required for any child who has mild to severe allergies and must be completed by the child's parent/guardian and the child's physician.

## Bright Horizons Allergy Health Care Plan

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**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: \_\_\_\_\_

Director/Principal: \_\_\_\_\_ 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 on the Allergy Awareness Chart.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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