Reach-Up
Head Start
Early Head Start

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United Way

Health – Plan of Care (Allergy)

Child: _____ D.O.B.: _____ Program: _____

Parent/Guardian(s): _____

The above Early Head Start/Head Start Child has an identified health concern. To provide an optimum experience for this child, additional information and instruction is needed from your Health Care Provider. Parent/Guardian signature is also needed where indicated below. Child cannot attend the program without this form completed. Thank you.

HEALTH CARE PROVIDER, PLEASE COMPLETE THE FOLLOWING:

Identified Health Concern:

***Allergy (P*lease specify):**_____

Medication is needed during program hours: Yes:_____No:_____

**If yes, "Permission to Administer Medication" form MUST be completed by the Health Care Provider before medicine can be given by Reach-Up, Inc. staff.*

Treatment

If a food allergen has been ingested, but no symptoms	☐Epinephrine ☐Antihistamine
Mouth-Itching, tingling, or swelling of lips, tongue, mouth	☐Epinephrine ☐Antihistamine
Skin-Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐Antihistamine
Gut-Nausea, abdominal cramps, vomiting, diarrhea	☐Epinephrine ☐Antihistamine
Throat-Tightening of throat, hoarseness, hacking cough	☐Epinephrine ☐Antihistamine
Lung-Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐Antihistamine
Heart-Thready pulse, low blood pressure, fainting, pale, blueness	☐Epinephrine ☐Antihistamine
Other_____	☐Epinephrine ☐Antihistamine
If reaction in progressing (several of the above areas affected)	☐Epinephrine ☐Antihistamine

ACTIVITY LEVEL / RESTRICTIONS: _____

EMERGENCY INSTRUCTIONS: _____

_____

OTHER RECOMMENDATIONS: _____

_____

Health Care Provider: _____ **Date:** _____

Parent/Guardian: _____ **Date:** _____

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Reach-Up Head Start and Early Head Start provides comprehensive education and support services that strengthen young children and their families who are experiencing low-income.