



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 (Please specify): _____

Medication is needed during program hours: Yes: _____ No: _____

Medication is needed during transportation on bus? 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 | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Mouth -Itching, tingling, or swelling of lips, tongue, mouth | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Skin -Hives, itchy rash, swelling of the face or extremities | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Gut -Nausea, abdominal cramps, vomiting, diarrhea | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Throat -Tightening of throat, hoarseness, hacking cough | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Lung -Shortness of breath, repetitive coughing, wheezing | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Heart -Thready pulse, low blood pressure, fainting, pale, blueness | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| Other _____ | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| If reaction in progressing (several of the above areas affected) | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

ACTIVITY LEVEL / RESTRICTIONS: _____

EMERGENCY INSTRUCTIONS: _____

OTHER RECOMMENDATIONS: _____

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

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

350 Highway 10 South Suite 100 | St. Cloud MN, 56304
 Voice: 320.253.8110 | Fax: 320.253.1107 | www.reachupinc.org