Child Health Plan and Provider Orders - Reflux Infants and Toddlers

Center: _____ ☐ Early Head Start ☐ Head Start ☐ ECEAP

Child's Name: _____ DOB: _____ Gender: M / F

Parent/Guardian: _____ Phone: (H) _____ (C) _____

Has Reflux beed diagnosed by a doctor? ☐ Yes (age: _____) ☐ No

What happens when your child experiences Reflux: (check all that apply)

☐Spitting up or vomiting ☐Arching the back in pain ☐Coughing
☐Poor feeding ☐Irritability or excessive crying ☐Blood in the stools

My child has experienced and/or is still experiencing the following symptoms:

Now	In the Past	
☐	☐	Poor Growth
☐	☐	Not eating due to discomfort and pain
☐	☐	Blood loss from acid burning the esophagus
☐	☐	Breathing difficulties
☐	☐	Other: _____

Call 911 for the following symptoms:
- Vomiting blood
- Difficulty breathing after vomiting or spitting up

The parent/guardian will be called immediately if any of the following symptoms occur:
- Vomiting large amounts or projectile (forceful) vomiting
- Vomiting fluid that is green or yellow
- Vomiting that looks like coffee grounds
- Blood in the stool

Accommodations that need to be made for my infant include:

☐Elevate the head of the infant's crib
☐Sit or hold the infant upright for 30 minutes after a meal
☐Smaller and more frequent feedings: Amount: _____ How often: _____
☐Thicken all liquids with _____ tbs of cereal or thickener
☐to _____ oz of milk/formula/other
☐to a consistency of (check one): ☐nectar ☐honey ☐pudding (MD Statement needed)
☐Burp well after feeding _____ oz.
☐Other: _____

Is medication(s) taken at home? ☐Yes ☐No (list): _____
Is medication(s) needed while at school? ☐Yes ☐No (If YES, refer to provider order's)

Child's Name: _____ DOB: _____ Gender: M / F

☐No medication is required at school (Please sign below if you agree with this CHP).

Health Care Provider Orders for Medication at School

Important notice to provider:
Please ensure this child has a prescription on file with the pharmacy that matches the orders below. **Our policy requires Health Care Provider Orders and medication labels to match exactly.**

1) Medication Name 2) Symptoms for medication use

3) Dose 4) Frequency & Length of time between doses 5) Route

6) Possible side effects of medication

7) Special administration and/or storage instructions

8) If PRN specify Start date: _____ **AND** End date: _____

Health Care Provider's Signature Date

Print name Phone # Fax #

Parent/Guardian Signature Date

Interpreter Signature Date

Nurse Consultant Signature Date

ITE/Teacher Date ITP/Assistant Date FA/FE/FSS/HV Date Dir/C Coor Date