

Child Health Plan and Provider Orders Form - 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 been 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 | |
|--------------------------|--------------------------|--------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Growth |
| <input type="checkbox"/> | <input type="checkbox"/> | Not eating due to discomfort and pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood loss from acid burning the esophagus |
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing difficulties |
| <input type="checkbox"/> | <input type="checkbox"/> | 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)

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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

Reviewed by: Health or Nutrition Coordinator / Nurse Consultant

Date

ITE/Teacher Date

ITP/Assistant Date

FA/FE/FSF/HV Date

Dir/C Coor Date