MEDICAL AND MEDICATION FORMS

508 N State Hwy 342, Red Oak, TX 75154
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This packet contains the following forms:

1. Medication Authorization
2. Food Allergy Emergency Plan
3. Dietary and Special Needs Plan
4. Infant Feeding Plan

Print only the form(s) you need. Complete the form, sign it, and return it to the Center Director. A separate form is required each time there is a change in medication, allergies, dietary needs, or feeding instructions.

Effective April 2026

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MEDICATION AUTHORIZATION

Complete this form when your child requires medication to be administered at the center.

Child's Full Name:

Date of Birth:

Parent/Guardian Name:

Medication 1

Medication Name:

Dosage/Amount:

Route (oral, topical, inhaled, etc.):

Time(s) to be given:

Start Date:

Stop Date:

Possible Side Effects:

Special Instructions:

Medication 2

Medication Name:

Dosage/Amount:

Route (oral, topical, inhaled, etc.):

Time(s) to be given:

Start Date:

Stop Date:

Possible Side Effects:

Special Instructions:

Authorization

I authorize the caregivers at Benevolent House Academy to administer the medication(s) listed above according to the instructions provided. I understand that:

All medication must be in the original, labeled container with the child's name, medication name, dosage, and directions. Medications are stored out of reach of children and refrigerated medications are stored separately from food. A medication administration log is maintained and available for parent review. Medications are returned to the parent when no longer needed or upon expiration.

Parent/Guardian Printed Name	*Date*

Parent/Guardian Signature

A separate form is required for each medication change.

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FOOD ALLERGY EMERGENCY PLAN

Required for children with diagnosed food allergies

Child Information

Child's Full Name:

Date of Birth:

Classroom/Age Group:

Parent/Guardian Name:

Parent Phone:

Parent Email:

Allergy Information

Diagnosed food allergies (list all):

Severity of allergic reaction:

- Mild (hives, itching, minor swelling)
- Moderate (widespread hives, facial swelling, vomiting, difficulty breathing)
- Severe / Anaphylaxis (throat swelling, drop in blood pressure, loss of consciousness)

Has your child ever had an anaphylactic reaction?

- Yes
- No

If yes, describe what happened:

Emergency Medications

Does your child have a prescribed epinephrine auto-injector (EpiPen)?

- Yes (parent must provide the EpiPen, labeled with child's name)
- No

Does your child have a prescribed antihistamine (such as Benadryl)?

- Yes (parent must provide, labeled, with dosage instructions)
- No

EpiPen expiration date:

Antihistamine name and dosage:

Other emergency medication:

Physician Information

Physician/Allergist Name:

Phone:

Address:

Emergency Action Steps

If my child has an allergic reaction, staff should follow these steps in order:

1. Remove the child from the food source immediately.
2. Assess symptoms. If the child shows ANY signs of a severe reaction (difficulty breathing, throat tightness, swelling of the tongue/lips, widespread hives with vomiting, dizziness, or loss of consciousness), administer the epinephrine auto-injector immediately and call 911.
3. If symptoms are mild (localized hives, minor itching), administer the prescribed antihistamine if authorized above.
4. Contact the parent/guardian immediately.
5. Monitor the child continuously. Symptoms can worsen rapidly.
6. If epinephrine is administered, call 911 even if symptoms improve. A second reaction (biphasic reaction) can occur.
7. Do NOT induce vomiting. Do NOT give the child anything to eat or drink unless directed by emergency personnel.
8. Complete an incident report on the day of occurrence.

Additional Instructions from Parent

Any other instructions or information staff should know:

Parent/Guardian Authorization

I authorize BHA staff to administer the emergency medications listed above in the event of an allergic reaction. I have provided the medications, labeled with my child's name. I understand it is my responsibility to replace expired medications and to notify the center immediately of any changes to my child's allergy information.

Parent/Guardian Printed Name *Date*

Parent/Guardian Signature

This plan is reviewed at enrollment and updated any time there is a change in allergy status, medication, or physician instructions. A copy is kept in the child's file and posted in the kitchen (first name only).

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DIETARY AND SPECIAL NEEDS PLAN

For children with cultural, religious, medical, or preference-based dietary needs

Child Information

Child's Full Name:

Date of Birth:

Classroom/Age Group:

Parent/Guardian Name:

Parent Phone:

Reason for Dietary Plan

- Cultural or religious dietary practices
- Medical dietary restriction (not a food allergy; if allergy, use the Food Allergy Emergency Plan)
- Vegetarian
- Vegan
- Parent preference
- Other (describe below)

Dietary Restrictions

Foods or ingredients my child may NOT eat:

Acceptable substitutions or alternatives:

Meals Affected

- Breakfast
- Morning Snack
- Lunch
- Afternoon Snack
- Supper (night care)
- Evening Snack (night care)
- All meals and snacks

Parent-Provided Food

Will you provide food for your child?

Yes, I will provide all meals and snacks for my child.

Yes, I will provide substitutions for specific items only (describe above).

No, I would like BHA to accommodate within the CACFP menu.

Parent-provided food must be labeled with the child's first and last name and date. If a parent-supplied meal does not meet nutritional guidelines, the center will supplement with additional food items.

Additional Instructions

Any other information about your child's dietary needs:

Parent/Guardian Acknowledgment

I have provided accurate information about my child's dietary needs. I understand it is my responsibility to notify the center immediately of any changes. If I am providing food, I will ensure it is labeled and meets nutritional standards.

Parent/Guardian Printed Name

Date

Parent/Guardian Signature

This plan is reviewed at enrollment and updated as needed. A copy is kept in the child's file. Dietary information is communicated to all caregivers in the child's classroom and to kitchen staff.

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INFANT FEEDING PLAN

Required for children 6 weeks through 12 months

Child's Full Name:

Date of Birth:

Parent/Guardian Name:

Date:

Feeding Type

Breast milk (parent provides, labeled with child's name and date)

Formula: Center-provided standard formula

Formula: Parent-provided specialty formula

Brand/Type:

Combination of breast milk and formula

Feeding Schedule

How often does your child eat?

Amount per feeding (ounces)?

Feeding cues to watch for:

Solid Foods

Has your child started solid foods?

Foods currently eating:

Foods to avoid:

Known food allergies:

Special Instructions

Other feeding instructions or preferences:

This feeding plan is reviewed and updated at least every 3 months or as your child's needs change. Parents are responsible for notifying the center of any changes to feeding instructions.

Parent/Guardian Printed Name

Date

Parent/Guardian Signature