Bright Horizons
GERD (Gastroesophageal Reflux Disorder) Care Plan

Child's Name: _____ Date of Birth: _____
Parent/Guardian's Names: _____
Child's Health Care Provider: _____ Phone: _____
Specialist: _____Phone: _____

Accommodations and modifications set out in this plan are to ensure that the child is properly cared for while at the center.

The following information should be completed by the child's health care provider:

Dietary Instructions: (Please check all that apply)

□Formula Type: _____

□ Breast Milk

□ Other permissible fluids (please specify): _____

□ Additives: (i.e. cereal added for thickened feedings-specify type and amount of additive)

_____
_____
_____

□ Solids: (Regular Diet For Age-unless specified):

_____
_____
_____

Feeding Guidelines: Please complete with any specific details

Offer fluid feedings every____hours or as needed. Suggested amount per feeding (provide a recommended range): _____ Offer solid feedings every_____hours	□ Bottle □ Cup □ Burp frequently after every: _____/oz_____ or as needed.
Upright Position Post Feeding for _____ (#minutes)(i.e. 30 minutes post feeding)	If asleep post feeding □ Crib w/wedge @ 30-45 degree angle If awake post feeding (select all possible options) □ Boppy Pillow (if available and permissible by licensing) □ Secured Infant Seat (if available and permissible by licensing) □ Held by child care provider □ Other: Please describe: _____ _____
Activities	□ May participate in all designated activities for age

Planned strategies/suggestions to support this child's needs and safety issues:
(Mealtime seating arrangement, meal/snack procedures, activities that involve food)

_____
_____
_____

Specific Medical Information:

Medical information exchange form on file: ☐ Yes ☐ No
(Release for the center to exchange medical information with the child's medical provider)

Medication to be administered: ☐ Yes ☐ No

☐ Medication Administration Form: completed by the Medical Provider and Parent/Guardian on file at the center (Including type of medication, method of administration, times, potential side effects,)

Additional medication information: _____

Special Staff Training Needs:

Type (be specific): _____

Training done by: _____Date of training: _____

Follow-up: Update/Revision:

This plan should be updated/revised annually or whenever the child's medication(s) or health status should change.
Date of update/revision: _____
Updated plan/revision on file: ☐ Yes ☐ No

Emergency Information:
Notify Parent/Guardian _____ Telephone number: _____
Emergency Contact _____ Telephone number: _____

This plan has been reviewed/approved by:

Signatures
Parent/Guardian: _____ Date: _____
Health Care Provider: _____ Date: _____
Bright Horizons Staff: _____ Date: _____
Bright Horizons Staff: _____ Date: _____
Bright Horizons Staff: _____ Date: _____

(This plan contains information from California Childcare Health Program (CCHP): http://www.ucsfchildcarehealth.org)

This plan must be updated annually, whenever there is any change in treatment or the child's condition changes.