EMERGENCY HEALTH CARE PLAN

Place Student's Photo Here

Student's Name: _____ D.O.B._____ Teacher: _____

ALLERGY TO: _____

Asthmatic: Yes* ☐ No ☐ *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:		Give Checked Medication**: (To be determined by family HCP)	
• If a food allergy has been ingested, but no symptoms:			
• Mouth	Itching, tingling, or swelling lips, tongue, mouth	___Epinephrine	___Antihistamine
• Skin	Hives, itchy rash, swelling of the face or extremities	___Epinephrine	___Antihistamine
• Gut	Nausea, abdominal cramps, vomiting, diarrhea	___Epinephrine	___Antihistamine
• Throat+	Tightening of throat, hoarseness, hacking cough	___Epinephrine	___Antihistamine
• Lung+	Shortness of breath, repetitive coughing, wheezing	___Epinephrine	___Antihistamine
• Heart+	Thready pulse, low blood pressure, fainting, pale, blueness	___Epinephrine	___Antihistamine
• Other+	_____	___Epinephrine	___Antihistamine
• If reaction is progressing (several of the above areas affected), give		___Epinephrine	___Antihistamine

The severity of symptoms can quickly change. +Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject™ 0.3 mg Twinject™ 0.15mg
(See reverse side for instructions)

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency Contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____
c. _____	1.) _____	2.) _____

EVEN IF PARENT/GUARDUAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Family HCP Signature _____ Date _____
Required