

EMERGENCY HEALTH CARE PLAN

Place
Child's
Picture
Here

ALLERGY

TO: _____

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

Asthmatic Yes* ☐ No ☐ *High risk for severe reaction

Signs of an allergic reaction include:

Systems:

Symptoms:

•MOUTH	itching & swelling of the lips, tongue, or mouth
•THROAT*	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
•SKIN	hives, itchy rash, and/or swelling about the face or extremities
•GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
•LUNG*	shortness of breath, repetitive coughing, and/or wheezing
•HEART*	"thready" pulse, "passing-out"

ACTION:

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

1. If ingestion is suspected, give _____ medication/dose/route
and _____ immediately!
2. CALL RESCUE SQUAD: (Request epinephrine) _____
3. CALL: Mother _____ Father _____ or emergency contacts
4. CALL: Dr. _____ at _____

**DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD
EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!**

Parent Signature

Date

Doctor's Signature

M.D.

Date

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. _____ Relation: _____ Phone: _____	1. _____ Room _____
2. _____ Relation: _____ Phone: _____	2. _____ Room _____
3. _____ Relation: _____ Phone: _____	3. _____ Room _____

For children with multiple food allergies, use one form for each food.

