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

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

ACTION:

1. If ingestion/sting is suspected, give _____ Medication/dose/route and _____IMMEDIATELY!

***If EPI PEN is needed: Child SHOULD ☐ Child SHOULD NOT ☐ carry on them. _____ **MD Initials**

2. CALL RESCUE SQUAD:_____

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 !!!!!

I give permission for the school nurse/designee to share this information with anyone who comes in contact with my child, so they may be aware of the treatment required.

_____ _____ _____M.D. _____

Parent Signature Date Doctor's Signature Date

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1._____	1._____
Relation:_____phone_____	room_____
2._____	2._____
Relation:_____phone_____	room_____
3._____	3._____
Relation:_____phone_____	room_____

10/08DJD