EMERGENCY HEALTH CARE PLAN

Place Child's Picture Here

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

ALLERGY TO: _____

History of previous reaction: _____

Asthmatic **Yes** _____ **No** _____

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
• **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**	"thread" pulse, "passing-out"

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

PLAN OF ACTION

1. If systemic allergic reaction is suspected, give _____ (medication/dose/route) and _____ immediately.
2. CALL 911 _____
3. CALL: Mother _____ Father _____ or emergency contacts
4. CALL: Dr. _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION AND CALL 911

_____ _____ _____ MD _____

Parent Signature Date Doctor's Signature Date

EMERGENCY CONTACTS

1. _____

Relation: _____ Phone: _____

2. _____

Relation: _____ Phone: _____

TRAINED STAFF MEMBERS

1. _____ RM # _____

2. _____ RM # _____

Location of EpiPens _____