EMERGENCY HEALTH CARE PLAN

ALLERGY TO:		
Student's Name:		
DOB:		
Teacher		
Asthmatic	Yes ☐ *	No ☐
*Denotes 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"
The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situations!	

Please check those actions which should be taken:

1. ☐ If ingestion is suspected, give (medication/dose/route) ______________ and ______________ **immediately!**
2. ☐ CALL RESCUE SQUAD: ______________
3. ☐ CALL: Mother ______________ Father ______________ or emergency contacts.
4. ☐ CALL: Dr. ______________ at ______________
5. ☐ **DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!**

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Parent Signature *Date* *Doctor's Signature* *Date*

Emergency Contacts		**Trained Staff Members**	
1.		1.	
Name/Relation	Phone	Name	Room
2.		2.	
Name/Relation	Phone	Name	Room
3.		3.	
Name/Relation	Phone	Name	Room

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