

EMERGENCY HEALTH CARE PLAN

PLACE CHILD'S PICTURE HERE	<b>ALLERGY TO:</b>	
	Student's Name:	
	DOB:	
	Teacher	
	Asthmatic	Yes <input type="checkbox"/> *      No <input type="checkbox"/>

\*Denotes HIGH RISK for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE	
Systems:	Symptoms:
<b>MOUTH</b>	itching & swelling of the lips, tongue, or mouth
<b>THROAT</b>	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
<b>SKIN</b>	hives, itchy rash, and/or swelling about the face or extremities
<b>GUT</b>	nausea, abdominal cramps, vomiting, and/or diarrhea
<b>LUNG</b>	shortness of breath, repetitive coughing, and/or wheezing
<b>HEART</b>	"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!**

\_\_\_\_\_  
Parent Signature                                      Date                                      Doctor's Signature                                      Date

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

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