COMPLETE THIS FORM ONLY IF YOUR CHILD HAS AN ALLERGY

EMERGENCY HEALTH CARE PLAN

ALLERGY TO: _____

Place Child's Picture Here

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

Teacher: _____

Asthmatic Yes* ( ) No* ( ) *High risk for severe reaction

♦ SIGNS OF AN ALLERGIC REACTION ♦

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 situation.

♦ ACTION FOR MINOR REACTION ♦

If only symptom(s) are: _____, give _____
Medication/dose/route

_____

Then call:
1. Mother _____, Father _____. or emergency contacts.
2. Dr. _____ at _____.

If condition does not improve within 10 minutes, follow steps 1-3 below.

♦ ACTION FOR MAJOR REACTION ♦

If ingestion is suspected and/or symptom(s) are: _____

give _____ IMMEDIATELY!
Medication/does/route

Then call:
1. Rescue Squad (ask for advance life support)
2. Mother _____, Father _____, or emergency contacts.
3. Dr. _____ at _____.

DO NOT HESITATE TO CALL RESCUE SQUAD!

_____ _____ _____ _____

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