

COMPLETE THIS FORM ONLY IF YOUR CHILD HAS AN ALLERGY

EMERGENCY HEALTH CARE PLAN

ALLERGY TO: _____

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/dose/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