

2015-2016

12

Emergency Health Care Plan

Place
Child's
Picture
Here

ALLERGY TO: _____

Child's Name: _____ D.O.B: _____ Teacher: _____

Asthmatic Yes (High risk for severe reaction) No

Signs of an allergic reaction include:

<u>Systems:</u>	<u>Symptoms:</u>
-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*	"freaky" pulse, "passing-out"

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

ACTION:

- If ingestion is suspected, give _____ medication/dose/route
and _____ immediately!
- CALL RESCUE SQUAD: _____
- CALL: Mother _____ Father _____ or emergency contacts
- CALL: Dr. _____ at _____

**DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD
EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!**

Parent Signature _____ Date _____ Doctor's Signature _____ M.D. _____ Date _____

EMERGENCY CONTACTS

1. _____
Relation: _____ Phone: _____
2. _____
Relation: _____ Phone: _____
3. _____
Relation: _____ Phone: _____

TRAINED STAFF MEMBERS

1. _____ Room _____
2. _____ Room _____
3. _____ Room _____

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

