EMERGENCY HEALTH CARE PLAN

Place Child's Picture Here

ALLERGY TO: _____

Student's Name: _____ DOB: _____ Teacher: _____

Asthmatic Yes ☐ * No ☐ *High risk for severe reaction

SIGNS OF 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 situation

ACTION:

1. If ingestion is suspected, give _____

2. CALL RESCUE SQUAD: _____

3. CALL: Mother _____ Father _____ or emergency contacts

4. CALL: Dr. _____ at _____

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

_____ _____ _____ M.D. _____

Parent Signature Date Doctor's Signature Date

EMERGENCY CONTACTS

1. _____ Relation: _____Phone: _____

2. _____ Relation: _____Phone: _____

3. _____ Relation: _____Phone: _____

For the safety of my child, I give my permission for this information to be posted in the classroom.

_____ _____

Parents Signature Date