Landmark PRESCHOOL

PLACE CHILD'S PICTURE HERE

EMERGENCY HEALTH CARE PLAN

Expiration Dates:
Epipen Jr. _____
Benedryl _____
Other:
_____ _____
Name of Drug Exp Date

ALLERGY TO: _____
Child's Name: _____ DOB: _____
Teacher: _____
Asthmatic: ☐ **Yes (High risk for severe reaction)**
☐ No

Signs of an allergic reaction include:

	Systems:	Symptoms:
•	Mouth	Itching and 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
•	Abdominal	Nausea, abdominal cramps, vomiting, and/or diarrhea
•	Lung*	Shortness of breath, repetitive coughing, and/or wheezing
•	Heart*	"Thready" pulse, loss of consciousness

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 _____(medication/dose/route) and _____ immediately.
2. CALL: Rescue Squad _____ Hospital: _____
3. CALL: Mother _____ Father _____ or emergency contacts below.
4. CALL: Dr. _____ at _____ (phone number).

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:

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.**
PLEASE NOTE YOUR CHILD MAY NOT REMAIN AT SCHOOL UNLESS/UNTIL THESE FORMS ARE COMPLETED.