Landmark
PRESCHOOL

PLACE CHILD'S PICTURE HERE

EMERGENCY HEALTH CARE PLAN

Expiration Dates:
EpiPen Jr.: _____
Benadryl: _____
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: Doctor: _____ at _____ (phone number).

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

_____ _____ _____ _____
Parent's Signature Date Doctor's Signature Date

EMERGENCY CONTACTS

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