



Allergic Reaction Emergency Health Care Plan

Student's name _____ DOB: _____

School: _____ Grade _____ Teacher: _____

Allergic to _____

Signs of an Allergic Reaction include: Please mark the typical reaction(s) for your child.

- 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
- GI Tract nausea, abdominal cramps, vomiting, and/or diarrhea
- Lungs* shortness of breath, repetitive coughing and/or wheezing
- Heart* thready pulse, "passing out"

*These symptoms can potentially progress to a life-threatening situation!

Action for minor reaction: _____

Action for Major reaction: **Immediately give the Epi-Pen (if available)**

Administer to thigh (hold in place and count to 10)

Call 911 then notify parent/guardian

Mother _____ at _____

Father _____ at _____

Other _____ at _____

I plan to keep an updated Epi-Pen at the school at all times. Yes ____ No ____

If any medication is to be given at school, please fill out a medication administration form.

I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

Parent/ Guardian Signature: _____

Date: _____ Relationship to student: _____