EMERGENCY HEALTH CARE PLAN

Student's Name _____ DOB _____

Address _____ Phone _____

Parent Name _____ Phone _____

Parent Name _____ Phone _____

Physician's Name _____ Phone _____

1. Emergency Contact _____

   Relationship _____ Phone _____

2. Emergency Contact _____

   Relationship _____ Phone _____

3. Emergency Contact _____

   Relationship _____ Phone _____

ALLERGY TO: _____

Asthmatic: **Yes*** **No** *** High risk for severe reaction**
(circle one)

SIGNS OF ALLERGIC REACTION INCLUDE
(Highlight those symptoms that might apply to the child)

SYSTEMS		**SYMPTOMS**
Mouth	_____	Itching & swelling of lips, tongue or mouth
Throat*	_____	Itching &/or sense of tightness in the throat, hoarseness & hacking cough
Skin	_____	Hives, itchy rash &/or swelling about the face or extremities
Gut	_____	Nausea, abdominal cramps, vomiting &/or diarrhea
Lungs*	_____	Shortness of breath, repetitive coughing &/or wheezing
Heart*	_____	"Thready" pulse, "passing out"

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

ACTION:

If contact with _____ is suspected,
(Allergen)

1. Give _____
2. Give _____
3. Give _____
4. Call EMS _____ 911
5. Call _____ parent

6. Administer 2nd dose of EpiPen in 15 minutes if no improvement & EMS not arrived

Permission to share information with school personnel (check where applicable):

Principal _____ Teachers _____ Support Staff _____ Student _____
Bus Company _____ Cafeteria Staff _____ School Nurse _____
Allergen Free Table in Cafeteria **Yes** _____ **No** _____

***** Do not hesitate to administer medication or call EMS even if parents or MD cannot be reached*****

_____ _____ _____ _____
Parent Signature Date Physician Signature Date