MIDDLEBOROUGH PUBLIC SCHOOLS
ALLERGY HEALTH CARE PLAN

Name:	Date:	Photo
Birth Date:		
School:	Grade:	
Teacher:		
SEVERE ALLERGY TO:		
Date of Last Reaction:		
Symptoms then:		

SIGNS OF AN ALLERGIC REACTION	
Symptoms to look for:	
MOUTH	itching & swelling of the lips, tongue or mouth, drooling
THROAT*	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough, choking
SKIN	hives, itchy rash, and/or swelling about the face or extremities, flushed face
GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG*	shortness of breath, repetitive coughing, and/or wheezing
HEART*	"thready" pulse, "passing-out", rapid heart rate
OTHER	dizziness, unsteadiness, sudden fatigue, chills, loss of consciousness
The severity of symptoms can quickly change ***Symptoms above can potentially progress to LIFE THREATENING situation.** **Do not hesitate to call 911**	

Health Care Plan:
Actions for a Minor Reaction

Actions for a Major Reaction
EPI PEN immediately

Other health concerns::	
Medications:	Dose / Time:
Dietary concerns / restrictions:	

Continued on Back

Parent Signature:*	Date:
M.D. Signature:	Date:
*Signature required	

Contact Information		
Parent / Guardian:	Home Phone:	
1.	Work:	Cell:
2.	Work:	Cell:

Home Address:	
Emergency Contact:	Phone:
Primary Care Physician:	Phone:
Allergist:	Phone:
Affiliated Facility:	Phone:
School Nurse:	Phone: