CRAVEN COUNTY SCHOOLS

Emergency Health Care Plan

ALLERGY TO:_____

Student's Name: _____DOB: _____Teacher:_____

Asthma Yes * No * *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

	Systems:	**Symptoms:**
·	MOUTH	itching & swelling of the lips, tongue, or mouth
·	THROAT*	itching and/or tightness in the throat, hoarseness, and hacking cough
·	SKIN	hives, itchy rash, and/or swelling about the face or extremities
·	GUT	nausea, abdominal cramps, vomiting and/or diarrhea
·	LUNG*	shortness of breath, repetitive coughing, and/or wheezing
·	HEART*	"thready" pulse, "passing out"

ACTION:

1. If ingestion is suspected, give _____

   Medication/dose/route

2. CALL RESCUE SQUAD (Request Epinephrine):_____

3. CALL: Mother_____ Father _____or emergency contacts

4. CALL: Dr._____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD

EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED

_____ _____ _____ _____

Parent/Guardian Signature Date Licensed Health Care Provider Date

EMERGENCY CONTACTS		TRAINED STAFF MEMBERS		Room #
1.		1.		
Relation:	Phone:	Relation:	Phone:	
2.		2.		
Relation:	Phone:	Relation:	Phone	
3.		3.		
Relation:	Phone:	Relation:	Phone	