

DAVISON COMMUNITY SCHOOLS

ALLERGY HEALTH CARE PLAN

Student's Name _____ Date of Birth _____
Teacher _____ Grade _____
Parent/Guardian _____ Phone Number _____
Work Number _____ Cell Number _____
Emergency Contact _____
(Name) (Relationship) (Phone Number)
Doctor's Name _____ Phone Number _____

ALLERGY TO: _____

Asthmatic? Yes* _____ No _____ (*High risk for severe reaction)

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems

Symptoms

*Mouth	Itching, swelling of the lips and/or tongue; drooling
*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
*Stomach	Nausea, abdominal cramps, vomiting and/or diarrhea
Lung	Shortness of breath; repetitive coughing and/or wheezing
Heart	"Passing out"; weak, rapid pulse

The severity of symptoms can quickly change.

*All above symptoms can potentially become life-threatening.

ACTION

If he/she should accidentally be exposed, the following procedure should be followed:

(Please check all that apply)

_____ Call 911
_____ Give medication: _____
_____ No medication is necessary. Please observe only.
_____ No action is necessary. It is not a life-threatening allergy.
_____ Other _____

Comments: _____

I understand that this information will be shared with school staff responsible for the care and management of the above health concern for my child.

Reviewed by:

Parent/Guardian _____ Date _____
School Representative _____ Date _____
Physician _____ Date _____

Please Fill Out Both Sides!