EMERGENCY HEALTH CARE PLAN FOR SEVERE ALLERGIC REACTION OR ANAPHYLAXIS (Not from Foods)

Student's Name_____ Photo

D.O.B._____ Teacher_____

ALLERGY TO:_____

Give any pertinent information or past medical history:

_____

Child has Asthma Yes_____ No_____

SIGNS OF ALLERGIC REACTION

- **MOUTH** Itching and swelling of the lips, tongue or mouth
- **THROAT** Itching and/or a sense of tightness in the throat, hoarseness,hacking cough
- **SKIN** Hives, itchy rash, and/or swelling of the face, extremities
- **GUT** Nausea, abdominal cramps, vomiting and/or diarrhea
- **LUNGS** Shortness of breath, repetitive coughing, and/or wheezing
- **HEART** Thready pulse, passing out

The severity of symptoms can quickly change. All can potentially progress to a life-threatening situation.

ACTIONS TO TAKE FOR A MINOR REACTION: If symptom(s)are_____

1. **Give**:_____

2. **Then call** Mother, Father, or Emergency Contact

3. **Then call** Dr._____ at _____.

ACTIONS FOR MAJOR REACTION: If exposure is suspected and child has a history of major reaction/and or symptoms are:_____

1. **Give**: _____**IMMEDIATELY!**
Medication/Dose/Route

2. Then call:
   1. **Rescue Squad 911** (ask for advance life support).
   2. **Mother, Father, or Emergency Contact**
   3. Dr._____ Hospital_____

DONOT HESITATE TO GIVE MEDICATION OR TO CALL RESCUE SQUAD!!

Additional Instructions:_____

_____ _____

Parent's Signature Date Doctor's Signature Date

EMERGENCY CONTACT		TRAINED STAFF MEMBERS	
Name	**Phone #**	**Name**	**Room #**
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____

PLEASE ATTACH SIGNED MEDICATION PERMIT/CONSENT TO CARRY IF APPLICABLE.