EMERGENCY HEALTH CARE PLAN

Student's Name: ____________________________________

Date of Birth: ______________ Grade: ____ ☐picture

ALLERGIC TO: _____________________________________
____

Asthmatic: Yes No *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems: Symptoms: (circle symptoms shown in past)

MOUTH	itching and swelling of the lips, tongue, or mouth
THROAT*	itching and/or a sense of tightness in the throat, hoarseness, cough
SKIN	hives, itchy rash, and/or swelling in face or extremities
GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG	shortness of breath, repetitive coughing, and/or wheezing
HEART	"thready" pulse, low blood pressure, "passing out"

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

ACTION:

1. If exposure is suspected, observe student for symptom of a reaction.
2. If symptomatic give _______________________________ immediately
   (medication/dose/route)
   and ____
3. Call 911
4. Call: Mother ___________________ Father ____________________
   Or emergency contacts:
   1. ________________________ Phone ____________________
   2. ________________________ Phone ____________________
   3. ________________________ Phone ____________________

______________________________ ______________________________

Parent Signature Health Care Professional Signature