

EMERGENCY HEALTH CARE PLAN FOR ALLERGIES

Allergy to: _____

Child's name: _____ D.O.B.: _____ Center/Teacher: _____

Asthmatic: Yes* No *High risk for severe reaction

** SIGNS OF AN ALLERGIC REACTION **

<u>Systems:</u>	<u>Symptoms:</u>
MOUTH	Itching & swelling of the lips, tongue, or mouth
THROAT	Itching and/or a sense of tightness in throat, hoarseness, 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"

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

Medication (if any) to be given for these symptoms:

Name of medication: _____ Dose: _____ Route: _____

If suspected allergic symptoms occur:

1. Give medication if prescribed and available
2. Call 911 and ask for advanced life support
3. Call mother _____ father _____
Or emergency contacts
4. Call Dr. _____ at _____
5. Provide first aide care as needed until ambulance personnel arrive

DO NOT HESITATE TO CALL 911!!

EMERGENCY CONTACTS:

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____
3. _____ Relationship: _____ Phone: _____

Parent's Signature

Date

Dr. Signature

Date