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EMERGENCY HEALTH CARE PLAN (Allergic Reaction)

ALLERGY TO: _____

Student's Name:_____ D.O.B._____Teacher_____

Asthmatic Yes* ☐ No* ☐ *High risk for severe reaction

Place Child's Picture Here

♦ SIGNS OF AN ALLERGIC REACTION ♦

Systems:	**Symptoms:**
▪MOUTH	itching & swelling of the lips, tongue or mouth
▪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
▪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.

♦ ACTION FOR MINOR REACTION ♦

If only symptom(s) are: _____, give_____
medication/dose/route

_____

Then call:

1. Mother_____, Father_____, or emergency contacts.

2. Dr. _____at_____

If condition does not improve within 10 minutes, follow steps 1-3 below.

♦ ACTION FOR MAJOR REACTION ♦

If ingestion is suspected and/or symptoms(s) are: _____

give _____IMMEDIATELY!
medication/dose/route

Then call:

1. Rescue Squad (ask for advanced life support)

2. Mother_____, Father_____, or emergency contacts.

3. Dr. _____at_____

DO NOT HESITATE TO CALL RESCUE SQUAD!

_____

_____ _____ _____ _____
Parent's Signature Date Doctor's Signature Date