



Saint Agatha School | Nurse's Office

RE: EMERGENCY HEALTH CARE PLAN 2025-2026

picture here

Allergy to: _____

Student's Name: _____ DOB _____ Teacher: _____

Asthmatic Yes _____ NO _____ *high risk for severe reaction _____

Symptoms: Please indicate typical symptoms pertaining to the child

Mouth Itching and swelling of the lips, tongue, or mouth

Throat Itching and/or sense of tightness in the throat, hoarse 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"

Any other Symptoms: _____

Has your child ever had to use an Epi-pen in the past: ____ Yes__ No__ (If yes, when: _____)

THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. * ALL THE ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION!

ACTION

1. If ingestion is suspected, give:

2. Call 911

3. Call Mother: _____ Father: _____ or emergency contacts

4. Call: Dr. _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATIONS OR CALL THE RESCUE SQUAD EVEN IF PARENTS OR DOCTORS CANNOT BE REACHED!

Parent signature _____ Date _____

I permit the school nurses to share information regarding my child's allergy to appropriate school personnel:

____ yes ____ No

Emergency Contacts



Saint Agatha School | Nurse's Office

Name: _____

Name: _____

Relationship: _____ Phone: _____ Relationship: _____ Phone: _____