Emergency Health Care Plan

Child's Name:_____ DOB:_____ Teacher:_____

List Allergies:_____

_____

Asthmatic: ☐ Yes (high risk for severe reaction) ☐ No

Signs of an allergic reaction include:

Systems:	Symptoms:
• MOUTH	itching and 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 the above symptoms can potentially progress to a life-threatening situation.

ACTION:

1. If ingestion is suspected give_____ (medication/dose/route) immediately!
   and_____
2. Call RESCUE SQUAD:_____
3. Call Mother_____ Father_____ or emergency contacts.
4. Call Dr._____ at_____

DO NOT HESITATE TO ADMINISTER MEDICATON OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

Parents signiture_____ Date_____

EMERGENCY CONTACTS

1. Name_____ Phone_____
   Relation:_____
2. Name_____ Phone_____
   Relation:_____
3. Name:_____ Phone_____
   Relation:_____