Earthplace

EMERGENCY HEALTH CARE PLAN

Child's Name: _____ D.O.B.: _____

ALLERGY TO: _____
(please be specific, especially for dairy product allergies)

History of Asthma: _____ Yes (high risk for sever reaction) _____ No

Signs of an allergic reaction include:

Systems	**Symptoms**
MOUTH	Itching and swelling of 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 and/or "passing out."

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

Action
If ingestion of insect sting is seen or suspected: (prescriber should number in order all appropriate actions)

_____ Observe child for severe symptoms.

_____ Administer EpiPen® before symptoms occur.

_____ Administer EpiPen® if symptoms occur.

_____ Administer Benadryl® (dose) _____ or Atarax® (dose) _____.

_____ Call 911 (and request a paramedic) and transport to ER if symptoms occur.

_____ Call 911 (and request a paramedic) and transport to ER if EpiPen® given.

DO NOT HESITATE TO ADMINSTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED!

_____ _____
(Parent Signature) (Date) (Prescriber Signature MD/APRN/PA) (Date)

_____ _____
(Parent Name—please print) (Prescriber Address) (Phone)

FOR CHILDREN WITH MULTIPLE ALLERGIES, USE ONE FORM FOR EACH ALLERGEN.