# Emergency Health Care Plan

Earthplace

*For children with multiple allergies, use one form for each allergen.*

## Student Information

Full Name: *(last, first)* DOB:

Allergy to:

*Please be specific, especially for dairy product allergies*

History of Asthma: **Yes**, high risk for severe 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:

**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 ADMINISTER 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 #*