

Emergency Health Care Plan

Student Name _____ DOB _____

Class and days in attendance _____

Allergic to _____ Asthmatic? _____

Known symptoms of an allergic reaction Number in order of occurrence...

System order Symptoms

Skin	___	Hives, itchy rash, and or swelling about face or extremities
Mouth	___	Itching and swelling of lips, tongue or mouth
Throat	___	Itching or tightness, hoarseness and/or cough
Lung	___	Shortness of breath, wheezing, cough
Gut	___	Nausea, cramps, vomiting and/or diarrhea
Heart	___	Thready pulse, passing out

ACTION

If ingestion is suspected, give the following immediately (circle and number)

___ Benadryl tsp.# ___ Capsules# ___

___ Other medication ___ Epi Pen (Jr.)

Call Rescue Squad then Call Mother # _____ Call Father # _____

Call Doctor # _____

Parent's signature _____ Date _____

Doctor's signature _____ Date _____

Additional Emergency Contacts

Name _____ Phone# _____

Name _____ Phone# _____