Emergency Health Care Plan

Name:
Teacher:
DOB: Weight:

ALLERGIC TO:

Asthma YES___ (increased risk for anaphylaxis) NO___

SYMPTOMS OF MILD ALLERGIC REACTIONS:

Known or Suspect of CONTACT!

- Sneezing
- Itching eyes
- Hives, rash especially around face
- Upset stomach or nausea

Action:

1) WASH FACE AND HANDS
2) **Call Parents**
3) Give **BENADRYL** – 2 chewable tablets or Meltaways (**25mg Total**) and **note time**
4) Observe child for 15 minutes- if symptoms **DO NOT IMPROVE call 911**
5) ***Follow protocol for severe reaction!***

SYMPTOMS OF SEVERE ALLERGIC REACTIONS:

Known or Suspect of INGESTION!

- Throat or chest tightness or change in voice
- Throat soreness or itching
- Swelling of eyes, mouth, lips
- Lethargy, confusion or agitation

Action:

1) **CALL 911-** state that the child is having an **ANAPHYLACTIC REACTION!**
2) ADMINISTER THE CHILD'S EPI PEN IMMEDIATLEY- note time.
3) Administer Benadryl – 2 chewable tables or Meltaways (25mg Total) and note time
4) Call Parents
5) If symptoms do not improve and EMS has NOT arrived, after 15 minutes give the 2nd EpiPen
6) Send to the Hospital for further observation/treatment- if 2nd EpiPen is available send it with the child in the ambulance.

DO NOT HESITATE IN ADMINISTRATING MEDICATION OR CALL 911 EVEN IF PARENTS CANNOT BE REACHED!

Parent Signature_____Date_____

EMERGENCY PHONE NUMBERS:

Home:

Mother's Work:
Cell:

Father's Work:
Cell:

Pediatrican:

Allergist:

Please indicate which number should be used first in an emergency!

Other Medical Information:

School Staff Trained (to be filled out by school nurse)
1)_____
2)_____
3)_____