EMERGENCY HEALTH CARE PLAN

ALLERGY TO: _____

Child's Name: _____ DOB:_____

Child Care Provider: _____

History of Asthma ☐ Yes (high risk for severe reaction) ☐ No

Signs of an allergic reaction include:

Systems	**Symptoms**
MOUTH	Itching & 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, "passing-out"

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

ACTION: If ingestion or 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

Preferred hospital:_____

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**

_____
Address **Phone**

EMERGENCY CONTACT

1. _____ Relation: _____
   Phone: _____
2. _____ Relation: _____
   Phone: _____
3. _____ Relation: _____
   Phone: _____