Emergency Health Care Plan - Food and Other Allergies

ALLERGY TO: _____

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

School: _____ **Grade:** _____ **Teacher:** _____

Asthmatic **Yes** **No** **(High risk for severe reaction)** **Yes** **No**

Please mark any signs or symptoms below that pertain to student:

Systems:	*Symptoms:*
_____MOUTH	itching and swelling of the 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"
_____OTHER	_____

The severity of symptoms can quickly change! All above symptoms can potentially progress to a life-threatening situation! Please list any other signs or symptoms that may indicate exposure: _____

_____

SPECIAL PRECAUTIONS: _____

_____

ACTION:

1. **If exposure is suspected give** _____
   Medication/dose/route
   And _____ **immediately!**
2. **CALL 911**
3. **CALL School Nurse and Parents or child emergency contacts**
4. **CALL DR:** _____
   Name **Phone Number**

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____ _____

PHYSICIAN SIGNATURE **DATE**

Physician Printed Name _____ **Phone** _____

(See back of sheet)

EMERGENCY CONTACT NUMBERS

(List in the order to be contacted)

1. Name: _____ **Phone Number** _____

2. Name: _____ **Phone Number** _____

3. Name: _____ **Phone Number** _____

4. Name: _____ **Phone Number** _____

FROM: Kirstie Stivers, RN, BSN
Lydia Middleton School Nurse

SCHOOL: _____
Fax #: _____

RE: Allergy

DATE:_____

STUDENT: _____ **DOB:** _____

Dear Parent or Guardian,

You have indicated an allergy or sensitivity to _____ on the student's health history form. In order for accommodations to be made at school, we must have a plan of care from the physician. Please fill out the attached form, have physician review, sign, and return to us along with an epi–pen.

If you do not have an appointment scheduled for the near future, your child's physician can Fax this form or his/her form stating that the child does have allergy, sources that must be avoided, and the emergency medications and action plan prescribed.

We encourage students to carry emergency medications with them if the physician and parents agree that the child is mature enough to carry and skilled in administration of such when needed.
An epi-pen should be kept in the nurse's office, also.

If you have any questions or concerns please feel free to contact the school and leave a message for me. I will return your call as soon as possible.

Thank you for your cooperation and for assisting in keeping your child safe at school.