

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 IMMEDIATELY-** 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 ADMINSTRATING 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:**

Pediatrician:

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) _____