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 CONTACTS	TRAINED STAFF MEMBERS
1. _____	1. _____ Room_____
Relation: _____ Phone _____	
2. _____	2. _____ Room_____
Relation: _____ Phone _____	
3. _____	3. _____ Room_____
Relation: _____ Phone _____	

For children with multiple allergies, use one form for each allergen