



# Student Health Services

## Emergency Allergy Health Care Plan

**ALLERGY TO:** \_\_\_\_\_

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Teacher:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **School:** \_\_\_\_\_

**\*Is child asthmatic? Yes \_\_\_ No \_\_\_**      **\*Inhaler at school? Yes \_\_\_ No \_\_\_ Carries \_\_\_**

### **SIGNS OF AN ALLERGIC REACTION INCLUDE:**

- 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
- GI TRACT:** (uncommonly) nausea, abdominal cramps, vomiting and/or diarrhea
- LUNGS:** Shortness of breath, repetitive coughing, and/or wheezing
- HEART:** Weak and "thread-like" pulse, "passing out"

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

### **ACTION:**

**1. If ingestion, exposure, or sting is suspected, give:** \_\_\_\_\_  
(Medication (s), dose, route-see Authorization Form)

**2. Call 911 or local Emergency Medical Services.**

**3. Call Parent/Guardian:**

Mother's Name: _____	Father's Name: _____
Home #: _____	Home #: _____
Work #: _____	Work #: _____
Mobile/Other: _____	Mobile/Other: _____
Address: _____	Address: _____
Email: _____	Email: _____

**4. Call MD** \_\_\_\_\_ **MD Phone:** \_\_\_\_\_

***\*ADMINISTER MEDICATION & CALL EMS EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED.***

Emergency Contacts (name and phone)	Trained Staff Members (name and room)
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

**I am the parent/guardian of \_\_\_\_\_ and request that the Emergency Allergy Health Care Plan utilized during school hours.**

**School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this form for Emergency Allergy Health Care authorizes Student Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.**

Physician/Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician name (print) and phone number: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_