

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

- | | |
|---|--|
| <p>MOUTH
 *THROAT
 SKIN
 GUT
 *LUNG
 *HEART</p> | <p>Itching & swelling of lips, tongue, or mouth
 Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
 Hives, itchy rash, and/or swelling about the face or extremities
 Nausea, abdominal cramps, vomiting and/or diarrhea
 Shortness of breath, repetitive coughing, and/or wheezing
 "Thready" pulse, "passing-out"</p> |
|---|--|

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

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