

ALLERGIC REACTION EMERGENCY HEALTH CARE PLAN

Student's Name: _____ D.O.B. _____

Teacher: _____ Grade: _____

ALLERGIC TO: _____

Is the child Asthmatic? Yes _____ No _____

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 "thready" 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, dose, route)
and _____ immediately.
2. Call 911 or local Emergency Medical Services.
3. Call: Mother:ph# _____ Father:ph# _____
Cell # _____ Cell # _____
4. Or call Dr. _____ at _____
Or call emergency contacts listed below.

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMS EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED.

I hereby give my permission for exchange of confidential information contained in the record of my child, _____ between _____
(Physician's Name)

and the Columbia County School System. I furthermore give Columbia County School System permission to perform the procedure or action as per physician's orders when orders are received. I understand that until the nurse receives the orders from my physician, I will be responsible for providing the services at school.

Parent/Guardian Signature

Date

Health Care Provider's Signature

Date

Emergency Contacts (name and phone)

Trained Staff Members (name & room#)

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____