EMERGENCY HEALTH CARE PLAN
FOR ALLERGIES

Allergy to: _____

Child's name: _____D.O.B.: _____ Center/Teacher:_____

Asthmatic: Yes* ☐ No ☐ *High risk for severe reaction

**** SIGNS OF AN ALLERGIC REACTION ****

Systems:	Symptoms:
MOUTH	Itching & swelling of the lips, tongue, or mouth
THROAT	Itching and/or a sense of tightness in throat, hoarseness, 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.
Medication (if any) to be given for these symptoms:

_____

_____

Name of medication: _____Dose:_____Route:_____

If suspected allergic symptoms occur:

1. Give medication if prescribed and available
2. Call 911 and ask for advanced life support
3. Call mother_____ father _____
   Or emergency contacts
4. Call Dr. _____ at_____
5. Provide first aide care as needed until ambulance personnel arrive

DO NOT HESITATE TO CALL 911!!

EMERGENCY CONTACTS:

1. _____Relationship:_____Phone:_____
2. _____Relationship:_____Phone:_____
3. _____Relationship:_____Phone:_____

_____

Part C: Head Start Staff Acknowledgment: By signing below, I acknowledge my responsibility to ensure the medication for the above-mentioned child is administer as directed in Part A.

Teacher: _____ Family Service Worker: _____

Assistant Teacher: _____ Team Leader: _____

Parent’s Signature Date Dr. Signature Date