



Emergency Care Plan

FOOD ALLERGY

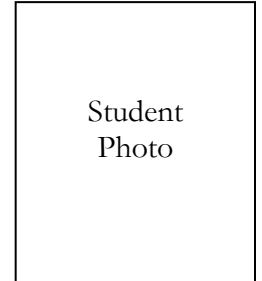


STUDENT: _____ GRADE: _____

ALLERGIC TO: _____

DOB: _____ Teacher: _____ SCHOOL YEAR _____

Asthmatic: Yes* No *Increased risk for severe reaction



SYMPTOMS:

GIVE MEDICATIONS Checked "X":

- | | | | |
|----------------|---|--|----------------------------------|
| MOUTH | Itching & swelling of lips, tongue or mouth "feels hot" | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epi Pen |
| THROAT* | Itching, tightness in throat, hoarseness, cough | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epi Pen |
| SKIN | Hives, itchy rash, swelling of face and extremities | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epi Pen |
| STOMACH | Nausea, abdominal cramps, vomiting, diarrhea | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epi Pen |
| LUNG* | Shortness of breath, repetitive cough, wheezing | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epi Pen |
| HEART* | Thready pulse, "passing out" | <input type="checkbox"/> Antihistamine | <input type="checkbox"/> Epi Pen |

The severity of symptoms can change quickly.

***All above symptoms can potentially progress to a life-threatening situation.**

1. If ingestion is suspected and/or symptoms are: _____

Give _____ IMMEDIATELY!
medication/dose/route

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medication/dose/route

Then call:

- Hatzalah 718-387-1750 or 718-230-1000 (inform them of type of emergency and ask for advanced life support)
- Mother: _____ Cell#: _____
Father: _____ Cell#: _____
- Dr. _____ at _____

Parent's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____