Emergency Care Plan

FOOD ALLERGY

STUDENT: _____ GRADE: _____

ALLERGIC TO: _____

DOB: _____ Teacher: _____ SCHOOL YEAR ____

Asthmatic: ❑ Yes* ❑ No *Increased risk for severe reaction

Student Photo

SYMPTOMS:		GIVE MEDICATIONS Checked "X":
MOUTH	Itching & swelling of lips, tongue or mouth, mouth "feels hot"	❑ Antihistamine ❑ Epi Pen
THROAT*	Itching, tightness in throat, hoarseness, cough	❑ Antihistamine ❑ Epi Pen
SKIN	Hives, itchy rash, swelling of face and extremities	❑ Antihistamine ❑ Epi Pen
STOMACH	Nausea, abdominal cramps, vomiting, diarrhea	❑ Antihistamine ❑ Epi Pen
LUNG*	Shortness of breath, repetitive cough, wheezing	❑ Antihistamine ❑ Epi Pen
HEART*	Thready pulse, "passing out"	❑ Antihistamine ❑ 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:
2. Hatzalah 718-387-1750 or 718-230-1000 (inform them of type of emergency and ask for advanced life support)
3. Mother: _____ Cell#: _____
   Father: _____ Cell#: _____
4. Dr. _____ at _____

Parent's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Revised 1/08