Emergency Care Plan

FOOD ALLERGY

STUDENT: : _____ GRADE: _____

ALLERGIC TO: _____

DOB: _____ Teacher: _____ SCHOOL YEAR _____

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

Parent's Signature: _____ Date: _____

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.**

TREATMENT: If ingestion is suspected and/or symptoms are as per the above:

Benadryl ordered: ❑ Yes ❑ No Give Benadryl ____mg PO per provider's orders.

Epinephrine ordered: ❑ Yes ❑ No Administer ❑0.15 mg ❑0.3 mg Epi Pen IM immediately.

Then call:

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

Physician's Signature: _____ Date: _____