

**\*\*Parents: Please complete back of this form. \*\* (over)**

**\*EMERGENCY HEALTH CARE PLAN**

**Physician:** Please complete:

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_

Allergy: \_\_\_\_\_

Is allergy *due to ingestion*? **Yes No** *by touch*? **Yes No**

Is this child at high risk for a severe allergic reaction? **Yes No**

Student has Asthma? **Yes No** Inhaler needed in school? **Yes No**

:

**1. Antihistamine:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_

For *MILD SYMPTOMS*: itchy mouth, a few hives around mouth, face, mild itch, and mild nausea (other) \_\_\_\_\_.

**2. Epinephrine IM** (circle one)

**Epi Pen Jr 0.15mg Epi Pen 0.3mg Twinject 0.15mg Twinject 0.3mg**

For *SEVERE SYMPTOMS*: progression of above symptoms, shortness of breath, trouble breathing/swallowing, swelling of throat, tongue, lips, wheeze, cough, pale, faint weak pulse, dizzy, confused, hives over body, vomiting, (other) \_\_\_\_\_

**3. Call 911**

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Physician's Phone # \_\_\_\_\_

**Parent:** Please complete: Emergency telephone contacts:

Mother (H) \_\_\_\_\_ (W) \_\_\_\_\_ Cell \_\_\_\_\_

Father: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Cell \_\_\_\_\_

I understand it is my responsibility to provide the school nurse with my child's medication(s) and the complete medication orders from the physician. If not provided, I understand no medications can be administered and 911 will be called.

**Parent's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

