SAINT MARY SCHOOL

Severe Allergy Emergency Health Care Plan

PARENT and PHYSICIAN FORM

Student's Name _____ DOB _____
Address _____ Phone _____
Parent Name _____ Cell _____
Parent Name _____ Cell _____
Physician's Name _____ Phone _____
Hospital Choice _____
1. Emergency Contact _____ Phone
   Relationship _____ Cell _____
2. Emergency Contact _____ Phone
   Relationship _____ Cell _____
3. Emergency Contact _____ Phone
   Relationship _____ Cell _____

ALLERGY TO: _____

Asthmatic: **Yes*** **No** *** High risk for severe reaction**
(circle one)

SIGNS OF ALLERGIC REACTION INCLUDE
(Circle those symptoms that might apply to the child)

SYSTEMS	**SYMPTOMS**
Mouth	itching & swelling of lips, tongue or mouth
Throat*	itching &/or sense of tightness in the throat, hoarseness & hacking cough
Skin	hives, itchy rash &/or swelling about the face or extremities
Gut	nausea, abdominal cramps, vomiting &/or diarrhea
Lungs*	shortness of breath, repetitive coughing &/or wheezing
Heart*	"thready" pulse, "passing out"

***** The severity of symptoms can change quickly. All above symptoms can potentially progress to a life threatening condition. *****

ACTION:

If contact with _____ is suspected,
(Allergen)

1. Give _____
2. Give _____
3. Give _____
4. Call EMS _____
5. Call _____
6. Call _____

Permission to share information with school personnel (where applicable):

Principal ____ All ____ Support Staff ____ Student ____ School Nurse ____
Bus Company ____ Teachers Cafeteria Staff ____

Allergen Free Table in Cafeteria **Yes** ____ **No** ____

***** DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMS EVEN IF PARENTS OR MD CANNOT BE REACHED*****

_____ _____ _____ _____
Parent Signature Date Physician Signature Date