Saint Mary School
RIDGEFIELD

Severe Allergy Emergency Health Care Plan

PARENT AND PHYSICIAN FORM

Student Name: ______________________________ DOB: ____________________

Address: ____________________ Phone: __________

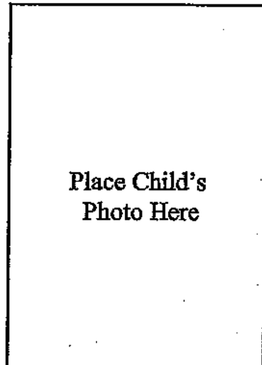
Mother's Name: ____________________ Phone: __________

Father's Name: ____________________ Phone: __________

Primary Physician: ____________________ Phone: __________

Hospital Choice: ______________________________

1. Emergency Contact: ______________________
   Relationship: ____________ Phone: __________
2. Emergency Contact: ______________________
   Relationship: ____________ Phone: __________
3. Emergency Contact: ______________________
   Relationship: ____________ Phone: __________



Place Child's Photo Here

ALLERGY TO: ______________________________

Asthmatic: ____ YES ____ NO ****High risk for severe reaction**

SIGNS OF ALLERGIC REACTION INCLUDE

(Circle those symptoms that may apply to the student.)

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
LUNG*	shortness of breath, repetitive coughing, &/or wheezing
HEART*	"thready" pulse, "passing out"

*****The severity of symptoms can quickly change. 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):

Parent/Guardian____ Principal____ Guidance Dept____ Teachers____ Student____
School Nurse ____ Lunch/Recess Paras ____ Cafeteria Staff ____ Bus Company____

Allergen Free Table in Cafeteria ____ YES ____ NO

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

Parent Signature	DATE	Physician Signature	Date