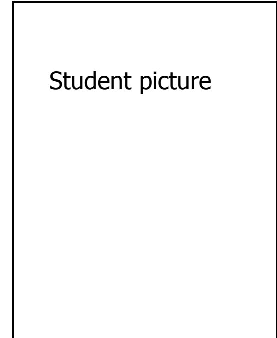
Emergency Care Plan for Severe Allergies

St. Joseph School, Brookfield, CT.

Parents please complete upper section

Student: ___________________________________ **DOB:** _______________ **Grade:** _______



Allergic to: ____

Parent: ________________________________ Parent: __________________________________

Home phone: _____________________ Home phone: _______________________

Cell phone: _______________________ Cell phone: ________________________

Work phone: ______________________ Work Phone: _______________________

Pediatrician: _________________________________ Phone: ____________________________

Allergist: _____________________________________ Phone: ____________________________

Please circle any signs or symptoms you child has during an allergy attack:

Signs of an allergic reaction

System	*Symptoms*
Mouth	itching and swelling of the tips, tongue, or mouth
Skin	hives, itchy rash, and /or swelling about the face or extremities
Gut	nausea, abdominal cramps, vomiting or diarrhea
Throat	itching and or sense of tightness in the throat, hoarseness, cough
Lung	shortness of breath, repetitive coughing, wheezing
Heart	"thready" pulse, passing out

WHAT TO DO: (to be completed by the Nurse)

1. ____

2. ____

3. ____

4. ____

5. ____

IF PARENT OR NURSE IS NOT AVAILABLE ON A FIELD TRIP: GIVE EPI PEN FIRST, THEN CALL 911

Yes___ No___ This student has been instructed in and understands the purpose and method of administration of epinephrine. He/she has both Prescriber and Parent permission to self-carry and administer EpiPen.

11/25/14