FOOD & NUTRITION MANAGEMENT
SOUTH HAMILTON COMMUNITY SCHOOLS

EMERGENCY HEALH CARE PLAN

PLACE CHILD'S PICTURE HERE

ALLERGY TO:_____

Student's name:_____ **Grade:**_____
Teacher:_____

ASTHMATIC: YES* **NO** ***high risk for severe reaction**

SIGNS OF ALLERGIC REACTION INCLUDE:

SYSTEMS:	SYMPTOMS:
MOUTH	Itching & swelling of lips, tongue, mouth
THROAT	Itching or tightness in throat, hoarseness, cough
SKIN	Hives, itchy rash, swelling fact/extremities
GUT	Nausea, cramping, vomiting, diarrhea
LUNG	Shortness of breath, coughing, wheezing
HEART	"thready" pulse, passing-out

ACTION: THE SEVERITY OF THE SYMPTOMS CAN CHANGE QUICKLY AND MAY PROGRESS TO A LIFE-THREATENING SITUATION!

To be completed by physician:

If ingestion/inhalation is expected give:

_____

And _____

immediately. (Please insert medication/dose/route)

1. Call Rescue Squad – 911. Request epinephrine? Yes No

2. Call Dr. _____**Telephone**_____

Drs. Signature:_____

Date_____

TO BE COMPLETED BY PARENTS:

MOTHER'S TELEPHONE: (HOME)_____**(WORK)**_____**(CELL)**_____

FATHER'S TELEPHONE: (HOME)_____**(WORK)**_____**(CELL)**_____

TO BE COMPLETED BY SCHOOL:

EMERGENCY CONTACTS: *Name* *phone number:*	*TRAINED STAFF MEMBERS:* *Name* *Room No.*
1	1
2	2
3	3

For children with multiple allergies, please use one form for each allergy.

Form distribution: 1. Food Service Director 2. Nurse's office 3. Teacher 4. Principal's office