EARLY LEARNING CAMPUS

ALLERGIC REACTION EMERGENCY PLAN

ATTACH CHILD'S PHOTO HERE

Child's Name _____

Allergic to:_____
(List all allergies)

Class/teacher: _____ Birth Date _____

Asthmatic Yes* No * High risk for severe reaction

- **Families: Please check the types of allergic reactions most likely experienced by your child. Check all that apply.**

	Symptoms
	Itching & swelling of the lips, tongue, mouth
	Itching and /or a sense of tightness in the throat, hoarseness, and hacking cough
	Hives, itchy rash, and/or swelling about the face or extremities
	Nausea, abdominal cramps, vomiting, and/or diarrhea
	Shortness of breath, repetitive coughing, and/or wheezing
	"Thready" pulse, "passing out"
	Other:

- **Families: Please indicate the plan that best addresses an allergic emergency should your child experience an allergic reaction.**

If ingestion of food that brings on an allergic reaction is suspected or if the child is having any of the above symptoms, do the following: (CHECK ALL THAT APPLY)

1. _____Administer prescribed epinephrine (EpiPen) immediately and/or (please circle one)…….

2. _____Administer other prescribed medication_____
Medication & dosage
_____
Medication & dosage

3. _____Call 911
4. _____Call CAREGIVER _____Phone_____
5. _____Call child's doctor:_____ Phone_____

_____
PRIMARY CAREGIVER'S Signature/Date