UNIVERSITY OF LOUISVILLE
EARLY LEARNING CAMPUS

FOR STAFF USE ONLY	
School Year	**2017-18**
Classroom	_____

Allergy/Asthma Emergency Plan

Child's Name: _____ **Birth Date:** _____

Allergic to (List all allergies): _____

_____

Asthmatic: Yes ☐ **No** ☐ **High Risk for Severe Reaction: Yes** ☐ **No** ☐

Please check the types of allergic/asthma reactions most likely experienced by your child. Check all that apply:

Asthma	Allergy	Symptom
☐	☐	Itching and Swelling of the lips, tongue, and/or 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 (Please Describe): _____

Please indicate the plan that best addresses an allergic/asthmatic emergency should your child experience an allergic/asthmatic reaction.

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

- ☐ **Administer prescribed epinephrine (EpiPen) immediately**
- ☐ **Administer other prescribed medication:**
  Medication and Dosage: _____
- ☐ **Call 911**
- ☐ **Call CAREGIVER**
  Name and Telephone Number: _____
- ☐ **Call Child's Doctor**
  Name and Telephone Number: _____

By signing this form, I acknowledge that in order to protect my child from allergen exposure, my child's allergy information may be posted around the center. This will serve as a visual reminder to those who may interact with my child throughout the day.

_____ _____

Signature of Parent or Guardian **Date**