School Year
20__ - 20__

Tri-County Community Council, Inc.
Head Start

Page to be completed with input by Parent/Guardian
Please Print

SEVERE ALLERGIC REACTION PLAN

Child Information
Center:________________________
Name of Child:________________________ Date of Birth:________________
Child's Age:______________ Classroom Teacher:________________________

Emergency Information
Parent(s') or Guardian(s') Names:________________________
Mother's Telephone (H):________________ Father's Telephone (H):________________
Pager:________________ Pager:________________
Telephone (W):________________ Telephone (W):________________
Primary Care Physician:________________ Telephone:________________
Preferred Local Emergency Department:________________________

In the event a parent/guardian cannot be reached:
1.________________ Relation:________________ Telephone:________________
2.________________ Relation:________________ Telephone:________________

List allergens of student:
____
____
____
____

Signs and symptoms:
1. Generalized tingling or itching
2. Hives all over body
3. Rapid pulse
4. Throbbing in ears
5. Difficulty in breathing
6. Facial flush
7. Swelling of lips or eyes
8. Loss of consciousness
9. Drooling and difficulty swallowing

My child has the following chronic illnesses/disabilities:
____
____

Child's limitations or special considerations:
____
____

ALL CURRENT MEDICATIONS

Name of Medication	Dosage and Strength	Purpose	Day Schedule	Time of Day

I understand that it is my responsibility to keep this information current. Please notify the Center Coordinator and provide an updated/current form on at least an annual basis.

Parent/Guardian's Signature:________________________ **Date:**________________

Child's

Name:__________

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SEVERE ALLERGIC REACTION PLAN

ACTION

1. In the event of an exposure to the above-mentioned allergen, DO NOT WAIT FOR SYMPTOMS.

2. Send child to the nearest Emergency Room by a staff member. Follow the individual considerations below.

3. **If child develops any breathing difficulty:**
   a. Delegate calls to:
      1. 9-1-1
      2. Parent/Guardian
      3. School health services

   b. Monitor airway, breathing, and pulse until arrival of 911, and begin Rescue Breathing/CPR for absent breathing/pulse.

Emergency Severe Allergic Reaction Medications

Name of Medication	Dosage and Strength	When to Use

Special Instructions

1.____

2.____

3.____

This child also has the following chronic illnesses/disabilities:

____

____

____

Physician's name:____

Physician's signature:__________________________________Date:______________

Teacher:____

Health Services Coordinator:_______________________________________