PIEDMONT PROGRESSIVE PRESCHOOL

EMERGENCY PLAN FOR ALLERGIC REACTIONS

ALLERGY TO: _____

Child's Name: _____ Date of Birth: _____

Does the child have asthma? *YES NO (*High Risk for severe reaction)

SYSTEMS	SYMPTOMS
Mouth	Itching & swelling of the lips, tongue, or mouth
Throat	Itching and/or a sense of tightness in the throat, hoarseness, and/or hacking cough
Skin	Hives, itchy rash, and/or swelling about the face or extremities
Gut	Nausea, abdominal cramps, vomiting, and/or diarrhea
Lungs	Shortness of breath, repetitive coughing, and/or wheezing
Heart	"Thready" pulse, fainting

The severity of symptoms can quickly change. All of the above symptoms can potentially progress to a life-threatening situation.

Action for MINOR reaction:

If symptom(s) are: _____

☐ Administer: _____

Medication/dosage/route

☐ Then call: _____

Parent/Guardian and Health Care Provider

☐ If condition does not improve within 10 minutes, follow steps for Severe Reaction below

Action for SEVERE reaction:

If symptom(s) are: _____

☐ Administer: _____

Medication/dosage/route IMMEDIATELY!

☐ Call: 911 (Never hesitate to call 911)

☐ Call: Parent or Guardian

☐ Call: Health Care Provider

Name: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

Health Care Provider Name: _____

Health Care Provider Signature: _____ Date: _____