ALLERGY INDIVIDUAL HEALTH CARE AND EMERGENCY TREATMENT PLAN

Child's Name	Today's Date
Parent's Name	Parent's Emergency Phone Number
Parent's Signature	
Child's Physician's Name	Child's Physician's Office Phone Number
Child's Physician's Signature	

My child is allergic to____

Emergency action is required when the child has symptoms such as: ____

STEPS TO TAKE DURING AN ALLERGY EPISODE

1. IF THE FOLLOWING SYMPTOMS OCCUR, GIVE THE MEDICATIONS LISTED BELOW.
2. CONTACT EMERGENCY HELP AND REQUEST EPINEPHRINE.
3. CONTACT THE CHILD'S PARENT OR GUARDIAN.

SYMPTOMS OF AN ALLERGIC REACTION INCLUDE: (PHYSICIAN, PLEASE CIRCLE THOSE THAT APPLY TO THIS CHILD)

- **Mouth/Throat:** itching or swelling of the lips, tongue, mouth, or throat; tightness of the throat
- **Skin:** hives, itchy rash, swelling
- **Gut:** Nausea; abdominal cramps; vomiting; diarrhea
- **Lung*:** Shortness of breath; coughing; wheezing;
- **Heart:** Pulse is hard to detect; 'passing out'

  * if the child has asthma, asthma symptoms may also need to be treated.

Emergency Allergy Medications:

Name	Amount	Route	When to Use

Special Instructions:

- ____
- ____

________________________________	________________________________	________________________________
Physician's Signature Date	Parent/ Guardian's Signature Date	Sprouts Staff Signature Date