



The Brook Hill School Health Manual

Individualized Health Care Plan Severe or Life Threatening Allergies

Student Name: _____ **Date of Birth:** _____

ALLERGIC TO: _____

Does student have Asthma? *Yes / No * Yes places student at a higher risk for severe reactions

SIGNS OF SEVERE ALLERGIC REACTION OR ANAPHYLAXIS

SYSTEM	SYMPTOM
Mouth	itching & swelling of lips, tongue or mouth
Throat	itching, sense of tightness, hoarseness or hacking cough
Skin	hives, itchy rash, or swelling about the face or extremities
Gastrointestinal	nausea, abdominal cramps, vomiting or diarrhea
Lungs	shortness of breath, repetitive coughing, and or wheezing
Heart	thready pulse, passing out

THE SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY!

DO NOT HESITATE TO CALL EMS

ALL OF THE ABOVE SYMPTOMS CAN LEAD TO A LIFE-TREATENING SITUATION

ACTION FOR MINOR REACTION

If my child demonstrates these symptoms: _____

Give: _____

Then call: Mother's cell #: _____ Father's cell#: _____ Physician's # _____

IF CONDITION DOES NOT IMPROVE WITHIN 10 MINUTES, FOLLOW THE PLAN BELOW

ACTION FOR MAJOR REACTION

If ingestion of allergen is suspected and symptoms are: _____

GIVE IMMEDIATELY _____

THEN CALL EMS

Then call: Mother's cell #: _____ Father's cell#: _____ Physician's # _____

Additional Emergency Contacts and #s: _____

Parent Signature: _____ **Physician Signature:** _____

Students with multiple allergies should use one form for each food or allergen