UNITED METHODIST CHILD CARE CENTER

EMERGENCY HEALTH CARE PLAN

ALLERGY TO: _____

Child's Name:_____ DOB:_____ Child Care Provider:_____

History of Asthma: Y (high risk for severe reaction) N

SIGNS OF ALLERGIC REACTION INCLUDE:

Systems	Symptoms
MOUTH	**Itching; Swelling of lips, tongue, or mouth**
***THROAT**	**Itching and/or a sense of tightness in the throat, hoarseness; hacking cough**
SKIN	**Hives, itchy rash, and/or swelling about the face or extremities**
GUT	***Nausea, abdominal cramps, vomiting and/or diarrhea***
***LUNG**	**Shortness of breath, repetitive coughing, and/or wheezing**
***HEART**	**"Thready" pulse, "passing out"**

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

Action:
If ingestion or insect sting is seen or suspected:
(Prescriber should number in order all appropriate actions)

_____ **Observe child for severe symptoms**
_____ **Administer EpiPen before symptoms occur**
_____ **Administer if symptoms occur**
_____ **Administer Benadryl (dose)_____ or Atarax (dose) _____**
_____ **Call 911 (and request a paramedic) and transport to ER if symptoms occur**
_____ **Call 911 (and request a paramedic) and transport to ER if EpiPen given**

Preferred hospital: _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED

_____ _____ _____ _____
PARENT SIGNATURE **DATE** **PRESCRIBER SIGNATURE MD/APRN/PA** **DATE**

_____ _____
ADDRESS **PHONE**

EMERGENCY CONTACTS

1. _____
   RELATION: _____ **PHONE:** _____
2. _____
   RELATION: _____ **PHONE:** _____
3. _____
   RELATION: _____ **PHONE:** _____

TRAINED STAFF MEMBERS

1. _____ **ROOM** _____
2. _____ **ROOM** _____
3. _____ **ROOM** _____
4. _____ **ROOM** _____