The Charles Finney School

EMERGENCY CARE PLAN

Student Name_____ DOB_____ Grade_____

IDENTIFIED ALLERGEN/ASTHMA/HEALTH CONCERN:

_____

STUDENT CONTACT INFORMATION:

Parent Name/Phone: _____
Parent Name/Phone: _____
Additional Contact Name/Phone: _____
Healthcare Provider Name/Phone: _____

SIGNS OF AN ALLERGIC REACTION - All symptoms can progress to be LIFE-THREATENING
General: Dizziness, loss of conscience, feeling of panic or doom
Mouth: Swelling of lips, tongue, face, throat, mouth may "feel hot"
Breathing: Wheezing, breathing difficulty, congestion, cough, throat tightness
Stomach: Discomfort, nausea, vomiting, abdominal cramps, diarrhea
Skin: Hives, rash, swelling

****ADMINISTER EPI-PEN FOR ALLERGIC REACTION AND CALL 911****

Benadryl:

Epi-pen:

Inhaler:

Treatment:

Health Care Provider Permission for Independent Use and Carry (*Inhalers/Epi-pens only)*
YES_____ NO_____

Primary Care Provider_____ Date _____

Parent Signature_____ Date _____

School Nurse Signature_____ Date _____

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