Oyster River Cooperative School District

EMERGENCY HEALTH CARE PLAN

Student's Name: _____DOB:_____Teacher/Homeroom/Grade_____

ALLERGY TO: _____ **School:**_____

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:	**Symptoms:***
***Mouth**	**itching & swelling of the lips, tongue, or mouth**
***THROAT**	**itching and/or a sense of tightness in the throat, hoarseness, and 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**	**"thread" pulse, "passing-out"**

The severity of symptoms can quickly change. *all above symptoms can potentially progress to a life-threating situation!

ACTION:

1. If ingestion is suspected, give_____

And_____immediately!

2. CALL 911: (request epinephrine) _____

3. CALL: Parent/Guardian _____ Parent/Guardian _____ or other emergency contacts _____.

4. CALL: Dr.: _____at_____

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

_____ _____ _____M.D._____

Parent(s) Signature **Date** **Doctor Signature** **Date**

EMERGENCY CONTACTS:

1._____

Relationship: _____Phone:_____

2._____

Relationship: _____Phone:_____

3._____

Relationship: _____Phone:_____

TRAINED STAFF MEMBERS:

1._____Room:_____

2._____Room:_____

3._____Room:_____

For children with multiple food allergies, use one form for each food allergy.

FAX #: ORHS=603-868-1355, ORMS=603-868-3469, MW=603-659-8612, MOH=603-742-7569

Last Modified 2/20/2015