Place Child's Picture Here

Please initial parental consent beside picture

CONCORD PUBLIC SCHOOLS CONCORD CARLISLE REGIONAL SCHOOL DISTRICT

EMERGENCY HEALTH CARE PLAN

For students at high risk for severe allergic reaction to a food or bee sting

Student's Name	:		D.O.B	Homeroom Teacher		
Allergy to:						
Asthmatic Yes_	No _	Special consideration	ons			
Signs of Allergi	c Reaction	Include:				
Throat itching and hives, itching and hives, itching and the shortness of		itching and/or a sense of ti hives, itchy rash and/or sw nausea, abdominal cramps	swelling of the lips, tongue or mouth /or a sense of tightness in the throat, hoarseness, and hacking cough rash and/or swelling about the face or extremities lominal cramps, vomiting, and/or diarrhea f breath, repetitive coughing, and/or wheezing rulse, "passing out"			
		s can quickly change. potentially progress to a life-th	reatening situation!			
ACTION:						
		vere allergic reaction, GIVElowed by	(medication/dose/route)			
*						
	Ordering	Physician's signature	Date	Telephone number		
2.	CALL RES	CUE SQUAD 911 (Request epin	ephrine) if Epi-pen given or	symptoms not responding		
3.	CALL (1st)	Parent	Tele. # / Cell #	OR		
(2) Parent	Tele. # / Cell #	OR		
4. EM	MERGENC		Name	Telephone number		
		2	Name	Telephone number		
I consent to			OR DOCTOR CANNO			
		Licensed Prescriber	to	Student		
I plan to kee	p an updat	ed Epi-pen in my child's backpac				
I understand	I may retr		ool at any time: however, the	e medication will be destroyed if it is not		
*						
	Parent	t/Guardian signature		Date		