FRIENDS' CENTRAL SCHOOL

Emergency Health Care Plan

Student's name: _____ **DOB**_____

Teacher's name: _____**Grade**_____ **Date**_____

Allergy to: _____

Signs of allergic reaction include: Check all that apply
Mouth: _____ itching, tingling, swelling of lips, tongue, or mouth
Throat: _____itching, sense of tightness in throat, hoarseness, hacking cough
Skin: _____ hives, itchy rash, or swelling of the face, arms, or legs
Gut: _____nausea, abdominal cramps, vomiting, diarrhea
Lungs: _____shortness of breath, repetitive coughing, wheezing
Heart: _____thready pulse, dizziness, fainting, or passing out

Action:
1._____
2._____
3._____

Emergency Contacts:
Parent 1: (print name) _____
home _____ **work** _____
cell _____
Parent 2: (print name) _____
home _____ **work**_____
cell _____

Contact: (relationship) _____
home _____ **work**_____
cell _____
Contact: (relationship) _____
home _____ **work** _____
cell _____
Contact: (relationship) _____
home _____ **work** _____
cell _____

Physician: (print name) _____
office phone _____

Parent's signature: _____**Date**_____