# RIDGEFIELD ACADEMY
## EMERGENCY HEALTH CARE PLAN

Student's Name _____ DOB _____

Address _____ Phone _____

Parent Name _____ Phone _____

Parent Name _____ Phone _____

Physician's Name _____ Phone _____

1. Emergency Contact _____

   Relationship _____ Phone _____

2. Emergency Contact _____

   Relationship _____ Phone _____

3. Emergency Contact _____

   Relationship _____ Phone _____

**ALLERGY TO:** _____

**Asthmatic:** **Yes*** **No** *** High risk for severe reaction**
(circle one)

**SIGNS OF ALLERGIC REACTION INCLUDE**
(Highlight those symptoms that might apply to the child)

| **SYSTEMS** | **SYMPTOMS** |
|---|---|
| **Mouth** | Itching & swelling of lips, tongue or mouth |
| **Throat*** | Itching &/or sense of tightness in the throat, hoarseness & hacking cough |
| **Skin** | Hives, itchy rash &/or swelling about the face or extremities |
| **Gut** | Nausea, abdominal cramps, vomiting &/or diarrhea |
| **Lungs*** | Shortness of breath, repetitive coughing &/or wheezing |
| **Heart*** | "Thready" pulse, "passing out" |

***** The severity of symptoms can change quickly. All above symptoms can potentially progress to a life threatening condition. *****

**ACTION:**
If contact with _____ is suspected,
(Allergen)

1. Give _____
2. Give _____
3. Give _____
4. Call EMS 911
5. Call parent

6. Administer 2nd dose of EpiPen in 15 minutes if no improvement & EMS not arrived

**Permission to share information with school personnel (check where applicable):**

Principal ____ Teachers ____ Support Staff ____ Student ____
Bus Company ____ Cafeteria Staff ____ School Nurse ____
**Allergen Free Table in Cafeteria** **Yes** ____ **No** ____

***** Do not hesitate to administer medication or call EMS even if parents or MD cannot be reached*****

_____ _____ _____ _____
Parent Signature Date Physician Signature Date