

# Child Care Emergency Plan for Food Allergic Reactions

**ALLERGY TO:** \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Asthma  Yes\*  No \*High Risk for severe reaction

## Signs of an allergic reaction

### Systems:

**MOUTH**

**THROAT**

**SKIN**

**GUT**

**LUNG**

**HEART**

### Symptoms:

itching & swelling of the lips, tongue, or mouth

itching and/or a sense of tightness in the throat, hoarseness and hacking cough

hives, itchy rash, and/or swelling about the face or extremities

nausea, abdominal cramps, vomiting, and/or diarrhea

shortness of breath, repetitive coughing, and/or wheezing

"thready" pulse, "passing-out"

*The severity of symptoms can quickly change. All the above symptoms can potentially be life-threatening.*

## ACTION FOR MINOR REACTION

If symptom(s) are: \_\_\_\_\_

Administer: \_\_\_\_\_

medication/dose/route

Then call: Parent/Guardian and Doctor

If condition does not improve within 10 minutes, follow steps for Severe Reaction below:

## ACTION FOR SEVERE REACTION

If symptom(s) are: \_\_\_\_\_

Administer: \_\_\_\_\_ **IMMEDIATELY!**

Medication/dose/route

**Call:** 911 (Never hesitate to call 911)

**Call:** Parent or Guardian

**Call:** Doctor

Parent/guardian \_\_\_\_\_ phone: \_\_\_\_\_ cell phone: \_\_\_\_\_

Parent/guardian \_\_\_\_\_ phone: \_\_\_\_\_ cell phone: \_\_\_\_\_

Doctor \_\_\_\_\_ phone # \_\_\_\_\_

Parent/guardian signature \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's signature (Required) \_\_\_\_\_ Date: \_\_\_\_\_