Emergency Health Care Plan for **ALLERGIES**

Name _____**DOB**_____**height**_____**weight**_____

Allergic to_____

_____

Asthmatic? Yes___or No____

Expected signs of Allergic Reaction, please circle all that apply:

Itching, Swelling of Lips and or Tongue, Itching inside throat, Sense of Tightness, Hoarseness

Coughing, Hives, Nausea, Vomiting, Shortness of Breath, Weak pulse, Fainting

Others signs or symptoms not mentioned here? Please list or describe them:

_____

_____

Treatment Plan (if contact or exposure occurs)

1. Give Medication
   Name of medication_____dose_____route_____
2. Second Medication
   Name of medication_____dose_____route_____

Emergency Contacts to be notified:

1. Parent/Guardian Name_____
   Phone: w_____m:_____home_____
2. Parent/Guardian Name_____
   Phone: w_____m:_____home_____
3. Emergency Contact#1 Name_____
   Phone: w_____m:_____home_____
4. Physician:_____phone_____

I authorize the staff of Congressional Schools and Camp to seek the appropriate emergency medical care for my child named _____ and to administer medications in the manner described above if an allergic response is suspected. I also give permission to share the above information with the professional staff of the Congressional School and Camp and Emergency personnel.

Parent/Guardian (print name)_____date_____

Physician signature_____phone_____