

New Haven Public Schools
Allergy Form/Care Plan

ALLERGY TO: _____ **Date:** _____

Students

Name: _____ D.O.B. _____ Teacher _____

Asthmatic (Y or N) ___Yes* ___No *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems: Symptoms:

- MOUTH itching & swelling of the lips, tongue, or mouth
- THROAT* itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- SKIN hives, itchy rash, and/or swelling about the face or extremities
- GUT nausea, abdominal cramps, vomiting, and/or diarrhea
- LUNG* shortness of breath, repetitive coughing, and/or wheezing
- HEART* “thready” pulse, “passing out”

The severity of symptoms can quickly change.

***All above symptoms can potentially progress to a life-threatening situation!**

ACTION:

1. If ingestion is suspected or documented give _____
2. Activate EMS: Call 911
3. CALL Parent: Mother _____ Father _____ or emergency contacts
4. CALL: Dr. _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS OR DOCTOR CAN NOT BE REACHED!

Parent Signature

Date

Doctor’s Signature

Date

EMERGENCY CONTACTS:	TRAINED STAFF MEMBERS
Name: Relation: Phone	Name: Room or phone number
Name: Relation: Phone	Name: Room or phone number
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For children with multiple food allergies, use one form for each food.