Fulton County Schools
Where Students Come First

Student Health Services

Emergency Allergy Health Care Plan

ALLERGY TO: _____

Student Name: _____ Date of Birth: _____

Teacher: _____ Grade: _____ School: _____

***Is child asthmatic? Yes _____ No _____ *Inhaler at school? Yes___ No ___ Carries_____**

SIGNS OF AN ALLERGIC REACTION INCLUDE:

MOUTH: itching and 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
GI TRACT: (uncommonly) nausea, abdominal cramps, vomiting and/or diarrhea
LUNGS: shortness of breath, repetitive coughing, and/or wheezing
HEART: weak and "thready" pulse, "passing out"

The severity of symptoms can change quickly. All of the above symptoms can potentially progress to a life-threatening situation.

ACTION:

1. **If ingestion, exposure, or sting is suspected, give**: _____
(Medication (s), dose, route-see Authorization Form)
2. **Call 911 or local Emergency Medical Services**.
3. **Call Parent/Guardian**:

Mother's Name: _____
Home #: _____
Work #: _____
Mobile/Other: _____
Address: _____
Email: _____

Father's Name: _____
Home#: _____
Work #: _____
Mobile/Other: _____
Address: _____
Email: _____

4. **Call MD** _____ **MD Phone**: _____

ADMINISTER MEDICATION & CALL EMS EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED.

Emergency Contacts (name and phone)	**Trained Staff Members (name and room)**
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

I am the parent/guardian of _____ and request that the Emergency Allergy Health Care Plan utilized during school hours.

School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this form for Emergency Allergy Health Care authorizes Student Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature: _____ Date: _____

Physician name (print) and phone number: _____

Parent Signature: _____ Date: _____

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