EMERGENCY ALLERGY/ASTHMA INFORMATION
2018-2019

Child's Name: _____D.O.B._____

ASTHMA (*Please check one*) ☐**Yes** ☐**No**

ALLERGY TO: _____

High Risk for Severe Reaction? ☐**Yes** ☐**No**

Reaction occurs upon: ☐**Ingestion** ☐**Contact w/ Skin** ☐**Environmental Exposure**

SIGNS OF ALLERGIC REACTIONS

(Please check the symptoms YOUR child is likely to exhibit)

SYSTEMS:	**SYMPTOMS:**
☐***MOUTH***	**itching and swelling of the lips, tongue, or mouth**
☐***THROAT***	**itching and/or a sense of tightness in throat, hoarseness, 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"**

ACTION:

Medication:_____ Dose:_____ Method:_____
Comments:

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Comments:

NOTE: You will be notified immediately if your child has an allergic reaction. 911 will be called immediately whenever necessary.

Parent's signature:_____ Date:_____

(revised 04/2017)