Butler County Children's Center, Inc.
Severe Allergy Care Plan
- To be completed by a Health Care Provider -

	Today's Date
Child's Full Name	Date of Birth
Parent's/Guardian's Name	Telephone No. ( )
Health Provider (Please Print)	Telephone No. ( )

SEVERE ALLERGY TO:

_____

_____

_____

SIGNS OF AN ALLERGIC REACTION	
MOUTH	Itching and swelling of the lips, tongue or mouth, drooling
THROAT	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough, choking
SKIN	Hives, itchy rash, and/or swelling about the face or extremities, flush face
GUT	Nausea, abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive coughing, and/or wheezing
HEARTH	"Thready" pulse, "passing-out", rapid heart rate
OTHER	Dizziness, unsteadiness, sudden fatigue, chills, loss of consciousness

The severity of symptoms can quickly change. If symptoms above progress to a LIFE-THREATENING situation, call 911

HEALTH ACTION PLAN

Actions for Minor Reaction: _____

_____

_____

_____

Actions for Major Reaction: _____

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More information on other side

Butler County Children's Center, Inc.
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- Continued –

Other Health Concerns:

_____

_____

_____

Medications	Dose/Time

Dietary Restrictions:

_____

_____

_____

Physician's Signature **Date**

PLEASE ATTACH ANY OTHER PERTINENT MEDICAL INFORMATION