

**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
Name: Relation: Phone	Name: Room or phone number

**For children with multiple food allergies, use one form for each food.**