



**TOWN OF COVENTRY DEPARTMENT OF PARKS & RECREATION
EMERGENCY HEALTH CARE PLAN FORM**

Child's Name: _____ Date of Birth: _____

ALLERGY TO: _____

History of Asthma: Yes No

Signs of Allergic Reaction Include (Please check all that apply):

- MOUTH: Itching & swelling of lips, tongue or mouth
- *THROAT: Itching and/or sense of tightness in the throat, hoarseness & hacking cough
- SKIN: Hives, itchy rash and/or swelling of 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 these symptoms can quickly change.

*All of the symptoms above can potentially progress to a life-threatening situation.

ACTION:

If ingestion or insect sting is seen or suspected:

(Prescriber should number in order (1-6) all of the appropriate actions)

- _____ Observe Child for severe symptoms
- _____ Administer Epi-Pen® before symptoms occur
- _____ Administer Epi-Pen® if symptoms occur
- _____ Administer Benadryl® (dose) _____ or Atarax® (dose) _____
- _____ Call 911 (and request paramedic) and transport to ER if symptoms occur
- _____ Call 911 (and request paramedic) and transport to ER if Epi-Pen® is given

Preferred Hospital: _____

**DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED**

Parent Signature Date: _____

Prescriber Signature (MD, APRN, PA) Date: _____

Parent Name (Printed)

Prescriber Name (Printed)

Parent Phone

Prescriber Phone