EMERGENCY HEALTH CARE PLAN

For students at high risk for severe allergic reaction to food or bee sting

(Fill out a separate form for each allergy if the medical response varies)

Student's Name:_____ YOG_____

Allergy to:_____

Special Considerations: _____

Signs of an allergic reaction include:

Symptoms

Mouth itching and swelling of the lips, tongue or mouth

Throat* itching and/or a sense of tightness in the throat, hoarseness, and hacking couch

Skin hives, itchy rash and/or swelling about the face or extremities

GI Tract nausea, abdominal cramps, vomiting and/or diarrhea

Lungs* shortness of breath, repetitive coughing and/or wheezing

Heart* 'thready" pulse, "passing out"

The severity of the above symptoms can quickly change.

***These symptoms can potentially progress to a life-threatening situation!**

Action:

1. For signs of a severe allergic reaction,**GIVE**_____
   (medication/dose/route)

   immediately, followed by_____ if needed.

******Ordering physician signature** _____ Date _____

2. **CALL** Rescue Squad 911 if Epi-pen given.

3, **CALL** parent/Guardian _____ Phone _____

I consent to have the school nurse or school personnel designated by the School Nurse administer the medication prescribed by:

_____ to _____

Licensed Prescriber Student's Name

I plan to keep an updated epi-pen in my child's backpack at all times: _____ yes _____ no

I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I understand I may retrieve the medication from the school at any time: *however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.*

Parent/Guardian Signature:_____ Date:_____

Relationship to student;_____

Emergency telephone numbers: _____