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
Thorat*     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
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.

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

3. **CALL** parent/Guardian ________________________________ Phone ____________________

******Ordering physician signature ___________________________ Date __________


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: ________________________________