ALLERGY
EMERGENCY CARE PLAN

To Be Completed by the Health Care Provider

Students Name:_____ Grade:___ Age:___ Date of Birth:_____
School:_____ Teacher:_____
Parent/Guardian name:_____ Phone (Home):_____(Cell)_____
Address: _____ Phone (work)_____
Health Care Provider Treating Student for Allergy: _____ Ph:_____

To provide assistance to a pupil experiencing an allergic reaction:

1. Type of Allergy:
   _____
2. Identify the triggers which start an allergic reaction:
   _____
3. Possible allergic signs
   _____

Other: _____

ACTIONS TO TAKE

Stay Calm
Stay with the student and call for help.
*Give medication (if prescribed).
Name of med: _____
Dose: _____
Route:_____
When to give/repeat: _____
Location of med:_____
OTHER: _____
Notify parents/guardian, and document what happened in child's file.
***by law a completed and signed Medication Form must be on file at the school before medication can be administered at school.**

CALL 911 IF STUDENT HAS:

~Difficulty breathing or noisy breathing
~Tightness of chest
~Swelling of tongue, eyes, or lips
~Swelling/tightness in throat
~Difficulty talking and/or hoarse voice
~A wheeze or persistent cough
~Loss of consciousness and/or collapse
~Vomiting, stomach cramps, or diarrhea
~Blue discoloration of lips or fingernails
~Become pale and floppy (young kids)

ADMINISTER CPR IF BREATHING STOPS!
CONTINUE UNTIL PARAMEDICS ARRIVE!

I authorize school personnel to implement this Allergy Emergency Plan as described.

_____ _____
Health Care Provider Signature Date

I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the authorized health care provider when necessary.

- **MY CHILD DOES NOT NEED SERVICES**

_____ _____
Parent/Guardian Signature Date