

Date Plan was Developed: _____

School Year: _____

Elma School District – Building: _____

SEVERE ALLERGY to (Specify) _____

Emergency Care Plan

Never send student with any allergic symptoms anywhere alone!!!!!!

Student Name: _____

DOB: _____

Student Picture

Asthmatic _____ **Yes**, this student is at HIGH RISK for severe reaction.

_____ **No**

Parent/Guardian: _____

Home Phone: _____

Work Phone _____

Emergency Contact: _____

Home Phone: _____

Work Phone: _____

Emergency Contact: _____

Home Phone: _____

Work Phone: _____

Physician: _____

Phone: _____

Preferred Hospital: _____

Current Medication: _____

Allergies: _____

SYMPTOMS and SIGNS of an ALLERGIC REACTION

Systems

Symptoms

Severity of symptoms can change quickly and rapidly progress to a life threatening situation!!!!

Mental

States feels “scared, something bad is going to happen”

Mouth

Itching and 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, stomach cramps, vomiting, and/or diarrhea

Lung

Shortness of breath, repetitive coughing, and or wheezing

Heart

Signs of shock, passing out

IF YOU SEE THIS

DO THIS

Never send student anywhere alone!!!!!!

TIME

Initial

**ANY OF THE ABOVE SIGNS
AND
SYMPTOMS
following exposure to _____**

**GIVE EPI-PEN IN UPPER, OUTER
THIGH- Can go through clothing**

CALL (9)- 911

Give Benadryl (____cc) _____ teaspoon by mouth. (Specific to student)

CALL PARENT

Keep student calm; if student complains of dizziness; have student lie down and elevate legs.

BREATHING STOPS

Begin CPR/RESCUE BREATHING

Note time of arrival and departure of ambulance; complete this form, initial, and send a copy of form with the ambulance.

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My signature below indicates my involvement and agreement with the above emergency action plan.

1.

2.

3.

Parent/Guardian Signature Date

MD/HCP Signature Date

Registered Nurse Signature Date

Dev. 4/12/01