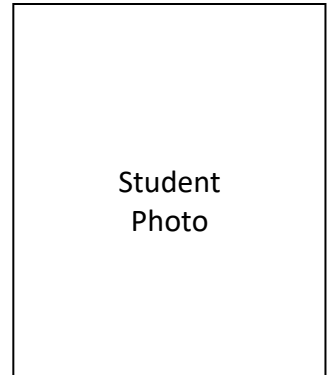


**Antietam School District  
Emergency Care Plan  
LATEX ALLERGY**

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_  
Mother: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Father: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:**

- . **MOUTH** Itching & swelling of lips, tongue or mouth
- . **THROAT** Itching, rightness in throat, hoarseness, cough
- . **SKIN** Hives, itchy rash, swelling of face and extremities
- . **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- . **LUNG** Shortness of breath, repetitive cough, wheezing
- . **HEART** "Thready pulse", "passing out"



**\*The severity of symptoms can change quickly... it is important  
that treatment be given immediately!**

**STAFF MEMBERS INSTRUCTED:** \_\_\_\_\_ Classroom Teacher(s) \_\_\_\_\_ Para-professionals  
\_\_\_\_\_ Specialty Area Teacher(s) \_\_\_\_\_ Administration \_\_\_\_\_ Support Staff \_\_\_\_\_ Transportation Staff

**TREATMENT:** Rinse contact area with water.

Benadryl ordered: \_\_\_\_\_ Yes \_\_\_\_\_ No Give \_\_\_\_\_ Benadryl per provider's orders

Call school nurse \_\_\_\_\_ Call parent/guardian if off school grounds \_\_\_\_\_

Epinephrine ordered: \_\_\_\_\_ Yes \_\_\_\_\_ No Special instructions: \_\_\_\_\_

**IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING ARE PRESENT  
AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.**

Preferred Hospital if transported: \_\_\_\_\_

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: \_\_\_\_\_ Medication available on bus \_\_\_\_\_ Medication NOT available on bus \_\_\_\_\_ Child does not ride bus

Special instructions: \_\_\_\_\_

Healthcare Provider \_\_\_\_\_ Phone: \_\_\_\_\_

Written by: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Signature** to share this plan with Provider and School Staff: \_\_\_\_\_

*This plan is in effect for the entire school year and summer school as needed.*