RYE CITY SCHOOL DISTRICT
Health Care Services
Rye, NY 10580

Place Child's Picture Here

ALLERGY
EMERGENCY HEALTH CARE PLAN

Name of Student: _____ **D.O.B:** _____/_____/_____ **Grade:** _____

ALLERGY TO: _____

Asthma Inhaler Order (check one): YES □ NO □ If YES, please complete a separate Asthma Emergency Health Care Plan

SYMPTOMS:

- Mouth - Itching, tingling, or swelling of lips, tongue, mouth
- Skin - Hives, itchy rash, swelling of the face or extremities
- Gut - Nausea, abdominal cramps, vomiting, diarrhea
- Throat - Tightening of throat, hoarseness, hacking, cough
- Lung - Shortness of breath, repetitive coughing, wheezing
- Heart - Thready pulse, low blood pressure, fainting, pale, blueness
- Other - _____
- If reaction is progressing (several of the above areas affected) give

REQUIRED ACTION:
- Stop all activity immediately
- Help student assume a comfortable position
- Notify school nurse

TREATMENT (Completed by physician)
Medication & Dosage:

Epinephrine Auto-Injector (check one): □ 0.3mg IM □ 0.15mg (Jr.) IM

Antihistamine Order (PRN):_____ /_____ /_____ /_____ /_____
Medication *Dose* *Route* *Frequency* *Indication*

Authorization for Self-Directed For EPI-Pen & Inhaler Only (check one): YES □ NO □

He/she is self-directed, has been instructed in the procedure of self-administration and can assume responsibility for carrying his/her own properly labeled medication in the original container. He/she understands the purpose, the correct dose, the possible side effects, and the frequency of use. I request that he/she be permitted to carry his/her own medication, including Field Trips, or to keep own medication in his/her locker. School Nurse has final approval.

Doctor's Signature: _____ **Date**_____
(Required)
Address: _____ Phone: _____

EMERGENCY ACTION

1. **Give medication as prescribed under Treatment.**
2. **CALL AMBULANCE: 911 (Police: (914) 967-1234). Inform that an allergic reaction is occurring. Bring epinephrine.**
3. **CALL PARENT/GUARDIAN:** _____

I request that my child receive the medication as prescribed above by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I give permission for my child to receive the prescribed medication as directed and under the supervision of the school nurse or designated other.

I release the Nurse to inform all those (Principal/Faculty/Staff directly involved with the student) on a "need-to-know" basis all pertinent health information for his/her safety during the school year.
Exceptions: _____

Parent/Guardian Signature: _____ **Date:** _____