



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)

STAMP/LICENSE/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: _____