Teacher: ____________________

Anaphylaxis or Allergic Reaction Emergency Health Care Plan

NAME: ________________________GRADE:______D.O.B.__________SCHOOL YR:_______

PARENT/GUARDIAN NAME:__________________________________Phone-Home ______________
Work: ____________________________ Phone- Cell: ____

ALLERGIES:____

MEDICATIONS: ____

Additional Medical Diagnosis: ____

EMERGENCY HOSPITAL: PHONE:

Health Care Provider: _____________________ Facility: __________________Phone: ___________

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PLAN: Health and Safety are the first priorities.

☐ *Signs/Symptoms: (Check all that may apply)*

__Coughing
__Sweating
__Nausea
__Abdominal cramps
__Sneezing
__General itching
__Vomiting

__Diarrhea
__Flushing of skin
__Dusky skin color
__Blue-gray color to lips/nails
__Difficulty breathing/talking
__Tightness of throat and/or chest

__Rash or hives
__Swelling of eyes, lips, tongue, throat, or neck
__Seizures
__Loss of consciousness
__Other (Explain) ______________________
____

Does he/she recognize these signs/symptoms? _______Yes ________No

ACTION:

☐ Adult to escort _________ to the health office (if able), or call health office for help.

☐ Trained staff will assist with medications as prescribed/authorized by physician and provided by parent.

☐ Encourage slow deep breaths. Keep comfortable, quiet place, sitting position.

☐ If Epi-Pen is used 911 will be called by a staff member.

☐ Page RN, or **if breathing difficulty call 911!** Follow health office emergency guidelines.

☐ Monitor Pulse and Blood Pressure

☐ If ________ shows or complains of any of these **symptoms on the bus, call 911** and follow bus emergency guidelines.

☐ Family member or emergency contact will be notified.

☐ __________ Carries an Epi-Pen with them
(Documentation required by Doctor)

☐ _________ Medication/s in Health Office

EMERGENCY PROCEDURE FOR AN ALLERGIC REACTION

STUDENT NAME: ____ D.O. B: __________

NAME OF DOCTOR/CLINIC: ________________________ PHONE: _____________________

Please complete and return to the health office as soon as possible. This information will be helpful in determining appropriate care for your child.

1. What is your child allergic to? (Bee stings, nuts, latex, meds, foods, etc.) ______________________
   ____
2. How long has your child has your child had this/these allergies? ____________________________
3. Please rate the severity of their allergy. **Not severe - 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 - severe**
4. How soon after contact does your child react? __________minutes, _________hours, __________days
5. What measures are taken at home when your child has a reaction? ______________________________
   ____.
6. What are the early-warning signs (physical and/or emotional changes) that indicate your child is starting to have an allergic reaction? ____
   ____.
7. What medications are given when your child has been exposed?
   Medication__________________________Medication__________________________
   Medication__________________________Medication__________________________
8. Does your child know how to self-administer Epinephrine using the Epi-Pen? ____Yes ____No
9. Will your child need to carry emergency medications on the bus? ____Yes ____No
10. Has your child ever been hospitalized for an allergic reaction? ____Yes ____No
11. Has your child been hospitalized or treated in the emergency room in the last year for an allergic reaction?
    ____Yes____No
12. Does your child know how to avoid causes of allergic reactions? ____Yes ____No
13. Is there any other information that you feel school should know regarding your child's health? ____________
    ____

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I have read and agree that the above procedure should be followed in the event that my child has a reaction at school, or a school activity. I understand that I am responsible for ensuring that emergency medications are available for my child, this includes when my child is at school, going to and from school, and while on field trips. I understand that I must provide a completed Authorization for Medication Form for any necessary medications before they can be given.

PARENT/GUARDIAN SIGNATURE: ____________________________________ **DATE:** __________

☐ Medication/Physician Orders (Health Office/File)

The following received copies and/or are trained to initiate plan:

Parent/Guardian ____ Health Office ____Para/Aide ____Bus Garage ____Teacher(s)____Coach ____ Other ____

**** Plan must be reviewed and signed **annually***** **Renewal Date:** ____________________