



# Emergency Care Plan

Sample



## FOOD ALLERGY

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ School Contact: \_\_\_\_\_ DOB: \_\_\_\_\_

Asthmatic:  Yes  No (increased risk for severe reaction) Allergen(s): \_\_\_\_\_

Mother: \_\_\_\_\_ MHome #: \_\_\_\_\_ MWork #: \_\_\_\_\_ MCell #: \_\_\_\_\_

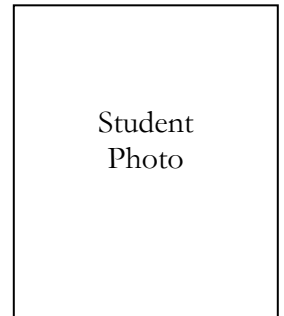
Father: \_\_\_\_\_ FHome #: \_\_\_\_\_ FWork #: \_\_\_\_\_ FCell #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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

- **MOUTH** Itching & swelling of lips, tongue or mouth “feels hot”
- **THROAT** Itching, tightness 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 is give immediately.**



### STAFF MEMBERS INSTRUCTED:

Administration

Classroom Teacher(s)

Support Staff

Special Area Teacher(s)

Transportation Staff

**TREATMENT:** Rinse contact area with water if appropriate

Treatment should be initiated  with symptoms  without waiting for symptoms

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 INGESTION OR SUSPECTED INGESTION OF ALLERGEN OCCURS, SYMPTOMS 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  Does not ride bus

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

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

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

Copy provided to Parent

Copy sent to Healthcare Provider

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