

Directions for filling out EMERGENCY CARE PLAN FOR ANAPHYLACTIC ALLERGIES form.

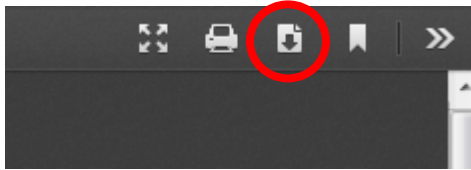
1. Use **Adobe Acrobat Reader** to view form.

- Click link below if download of Adobe Acrobat Reader is necessary.

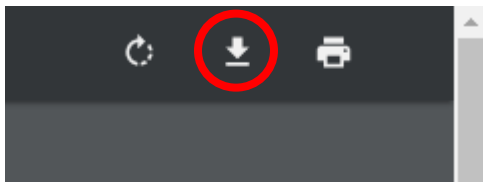


2. Please **DOWNLOAD and OPEN** file locally before completing by clicking the download icon in browser being used.

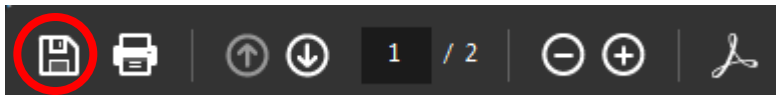
- **Firefox browser**



- **Google Chrome browser**



- **Internet Explorer browser**



3. Please submit the completed forms to the School Office.

EMERGENCY CARE PLAN FOR ANAPHYLACTIC ALLERGIES
SCHOOL YEAR 2018-2019

Last Name _____ First Name _____ Grade _____ Teacher _____

Allergens: _____ Birthdate _____

Has epi-pen ever been used in the past? Yes No If yes, when? _____

Asthmatic? Yes No Inhaler at school? Yes No

Father's Last Name _____ First Name _____

Home Phone _____ Cell Phone _____ Work Phone _____

Mother's Last Name _____ First Name _____

Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contact Name _____ Relationship _____ Contact No. _____

Emergency Contact Name _____ Relationship _____ Contact No. _____

Symptoms of an allergic reaction may include any/all of these: (Check appropriate boxes.)

▶ Mouth	Itching & swelling of lips <input type="checkbox"/>	Itching & swelling of tongue or mouth <input type="checkbox"/>	Mouth "feels hot" <input type="checkbox"/>
▶ Throat	Tightness in throat <input type="checkbox"/>	Itching <input type="checkbox"/>	Hoarseness <input type="checkbox"/>
▶ Skin	Swelling of face & extremities <input type="checkbox"/>	Itchy rash <input type="checkbox"/>	Hives <input type="checkbox"/>
▶ Stomach	Nausea/Vomiting <input type="checkbox"/>	Abdominal cramps <input type="checkbox"/>	Diarrhea <input type="checkbox"/>
▶ Lung	Shortness of breath <input type="checkbox"/>	Repetitive cough <input type="checkbox"/>	Wheezing <input type="checkbox"/>
▶ Heart	"Thready pulse" <input type="checkbox"/>	Dizzy/"Passing out" <input type="checkbox"/>	Pale <input type="checkbox"/>

Staff members notified of allergy: Homeroom Teacher Nurse Other staff _____

TREATMENT PLAN FOR SCHOOL STAFF TO FOLLOW (To be filled out by parents or doctor.)

▶ **Call school nurse.** ▶ **Call Parent/guardian as soon as possible.** ▶ **If ingestion or suspected ingestion of allergen occurs and symptoms are present and epinephrine is ordered, give epinephrine immediately and call 911.**

Treatment should be initiated with symptoms without waiting for symptoms

Benadryl ordered Yes No Dosage _____ of Benadryl per provider's orders

Epinephrine ordered Yes No Special instructions _____

Location of Epinephrine Nurse's office Main Classroom With student Other _____

Expiration Date of Epinephrine _____

Preferred hospital if transported _____

Doctor's Name _____ Contact No. _____

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 others is present.

HEALTHCARE PROVIDER: _____ PHONE: _____

PARENT'S/GUARDIAN'S SIGNATURE: _____ DATE: _____