ALLERGIC REACTION EMERGENCY HEALTH CARE PLAN

ALLERGY TO: _____

Student's Name: _____ D.O.B. _____

Teacher: _____ Classroom: _____

Is child asthmatic? **Yes** _____ **(Higher risk of severe reaction!)** **No** _____

Signs of an Allergic Reaction Include (Circle student's usual symptoms):

MOUTH: itching and swelling of the lips, tongue or mouth

THROAT: itching and/or a sense of tightness in the throat, hoarseness and hacking cough

SKIN: hives, itchy rash and/or swelling about the face or extremities

GI TRACT: (uncommonly) nausea, abdominal cramps, vomiting and/or diarrhea

LUNGS: shortness of breath, repetitive coughing and/or wheezing

HEART: weak and "thready" pulse, "passing out"

The severity of symptoms can change quickly. All of the above symptoms can potentially progress to a life-threatening situation.

ACTION:

1. If ingestion, exposure or sting is suspected, give _____
(medication, dose, route)

and _____ immediately.
(other actions to be taken)

2. Call 911 or local Emergency Medical Services.

3. Call: Mother/Guardian:ph# _____ Father:ph# _____

Pgr/cell# _____ Pgr/cell # _____

Other emergency contacts _____

4. Or call Dr. _____ at _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMS EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED.

_____ _____

Parent/Guardian Signature Date

_____ _____

Healthcare Provider's Signature Date

Staff members trained to give Epipen® as listed above (name and room #)
1:
2.
3.

Authorization for Student to Carry a Prescription Inhaler, EpiPen® or Insulin

_____ needs to carry the following prescription labeled inhaler, EpiPen® or insulin with him/her. The above named student has been instructed in the proper use of the medication and fully understands how to administer this medication. (It is preferable that a second prescription labeled inhaler, EpiPen® or additional insulin be kept in the clinic in case the first is lost or left at home.)

_____ _____

Medication Dosage and Directions

_____ _____

Physician's Signature or Stamp Date

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I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the school nurse to keep her informed of use of my medication in case I start having problems.

_____ _____

Student's Signature Date

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I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above, at school. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the RCBOE school district and its employees of Any legal responsibility when the above named student administers his/her own medication.

_____ _____

Parent/Guardian Signature Date

* All signatures must be provided for form to be Valid.