EMERGENCY HEALTH CARE PLAN

ALLERGY TO: _____________________________________________________

____________________________ _________________    __________________
Student’s Name       D.O.B.            Teacher

Asthmatic: Yes* ☐ No ☐  *High risk for severe reaction

Food Allergy: Yes ☐ No ☐ If yes, allergy is a disability that affects major life activity. Explain:
__________________________________________________________________________________________
__________________________________________________________________________________________

List food(s) to be omitted from the diet and food(s) that may be substituted (Diet Plan): _______________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Special Equipment: _________________________________________________________________________
__________________________________________________________________________________________

SIGNS OF AN ALLERGIC REACTION:

<table>
<thead>
<tr>
<th>Systems</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mouth</td>
<td>Itching and swelling of the lips, tongue or mouth</td>
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<tr>
<td>Throat*</td>
<td>Itching and/or a sense of tightness in the throat, hoarseness and hacking cough</td>
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<tr>
<td>Skin</td>
<td>Hives, itchy rash and/or swelling about the face or extremities</td>
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<tr>
<td>Gut</td>
<td>Nausea, abdominal cramps, vomiting and/or diarrhea</td>
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<tr>
<td>Lung*</td>
<td>Shortness of breath, repetitive coughing and/or wheezing</td>
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<tr>
<td>Heart*</td>
<td>“Thready” pulse, “passing out”</td>
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</tbody>
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*The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation.
ACTION FOR MINOR REACTION:
If only symptom(s) are ________________________________, give ______________________________________

__________________________________________________________________________________________

then call

1) Mother _____________________, Father _____________________ or emergency contacts.
2) Doctor _____________________ at __________________________

If condition does not improve within 10 minutes, follow steps 1-3 below.

ACTION FOR MAJOR REACTION:
If ingestion is suspected and/or symptom(s) are ________________________________________________,
give _________________________________________________________________________ immediately.

__________________________________________________________________________________________

then call

1) Rescue Squad (ask for advanced life support)
2) Mother ________________________, Father ______________________ or emergency contacts.
3) Doctor ________________________ at ___________________________

DO NOT HESITATE TO CALL RESCUE SQUAD!

<table>
<thead>
<tr>
<th>EMERGENCY CONTACTS</th>
<th>TRAINED STAFF MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ________________</td>
<td>1. ________________Room: ___</td>
</tr>
<tr>
<td>Relation: __________</td>
<td>Phone: __________</td>
</tr>
<tr>
<td>2. ________________</td>
<td>2. ________________Room: ___</td>
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<tr>
<td>Relation: __________</td>
<td>Phone: __________</td>
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EPIPEN AND EPIPEN JR. DIRECTIONS
1. Pull off gray activation cap.
2. Hold black tip near outer thigh (always apply to thigh).
3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 10 seconds.

___________________________ ____________________________ ___________
Parent’s Signature Date Doctor’s Signature Date
ASTHMA INHALERS/EPINEPHRINE AUTO-INJECTOR- SELF-ADMINISTRATION BY STUDENTS

Student's Name ___________  Grade ___________  Date ___________

To self-medicate, the student must be able to: (check all that apply)

_____ 1. Respond to and visually recognize his/her name.

_____ 2. Identify his/her medication.

_____ 3. Demonstrate the proper technique for self-administering his/her medication.

_____ 4. Sign his/her medication sheet to acknowledge having taken the medication.

_____ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

Name of Medication _________  Dosage _________  Frequency _________

The above named student has demonstrated the ability to self-administer the physician-prescribed asthma/allergy medication, as indicated by the criteria listed above.

Date ___________  Signature (Certified School Nurse) ___________

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above named medication will result in the immediate confiscation of the inhaler/epinephrine auto-injector and loss of privilege to self-administer if the medication policy is violated.

Date ___________  Parent/Guardian Signature ___________

I agree to be solely responsible for my asthma inhaler/epinephrine auto-injector and to follow the directions for its use as ordered by my physician, as well as the district’s medication policy. I am aware that any abuse of this privilege will result in the confiscation of my inhaler/epinephrine auto-injector.

Date ___________  Student's Signature ___________