Manheim Central School District

Preparing Responsible Citizens, Who Are Lifelong Learners

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EMERGENCY HEALTH CARE PLAN

Place Child's Picture Here

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:

Systems	**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
Gut	Nausea, abdominal cramps, vomiting and/or diarrhea
Lung*	Shortness of breath, repetitive coughing and/or wheezing
Heart*	"Thready" pulse, "passing out"

**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 _____

Medication / Dose / Route

_____

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.

Medication / Dose / Route

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!

EMERGENCY CONTACTS	TRAINED STAFF MEMBERS
1. _____ Relation: _____ Phone: _____ 2. _____ Relation: _____ Phone: _____ 3. _____ Relation: _____ Phone: _____	1. _____ Room: ____ 2. _____ Room: ____ 3. _____ Room: ____

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