Bethlehem Central School District Health Services

EMERGENCY CARE PLAN – SEVERE FOOD ALLERGY

Student Name: _____ **DOB:** _____

Grade/Class/Team/Homeroom: _____ _____

ALLERGY TO: _____

Asthmatic: ❑ Yes ❑ No (*Asthmatics have an increased risk for severe reaction*)

STEP 1: TREATMENT

Symptoms	**Give Checked Medication** (to be determined by provider authorizing treatment)	
• If food allergen ingested, but *no symptoms*	☐ **Epinephrine**	☐ **Antihistamine**
• Mouth-Itching, tingling, or swelling of lips, tongue, mouth	☐ **Epinephrine**	☐ **Antihistamine**
• Skin-Hives, rash, swelling of face or extremities	☐ **Epinephrine**	☐ **Antihistamine**
• Gut-Nausea, cramps, vomiting, diarrhea	☐ **Epinephrine**	☐ **Antihistamine**
• Throat*-Tightening, hoarseness, hacking cough	☐ **Epinephrine**	☐ **Antihistamine**
• Lung*-Shortness of breath, repetitive cough, wheezing	☐ **Epinephrine**	☐ **Antihistamine**
• Heart*-Weak or thready pulse, low blood pressure, pale, blue	☐ **Epinephrine**	☐ **Antihistamine**
• Other*-_____	☐ **Epinephrine**	☐ **Antihistamine**
• If reaction is progressing (several of above areas affected), give:	☐ **Epinephrine**	☐ **Antihistamine**

Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: Inject intramuscularly (please check one)

☐ **Epinephrine 0.3 mg (EpiPen®,Auvi-Q®,Symjepi®,Adrenaclick®)** ☐ **Epinephrine 0.15mg (EpiPen Jr®,Auvi-Q®,Symjepi®,Adrenaclick®)**

Antihistamine (medication, dose, route):_____

Other (medication, dose, route): _____

☐ **Student may carry medication and can effectively self-administer independently at school/school activities**

IMPORTANT: INHALERS AND/OR ANTIHISTAMINES CANNOT BE DEPENDED ON TO REPLACE EPINEPHRINE

STEP 2: EMERGENCY CALLS

1. CALL 911 (state that an allergic reaction has been treated and additional epinephrine may be needed)

2. Physician/Provider:_____ **Phone:**_____

3. Emergency Contact-Name/ Relationship_____ **Phone(s):** _____

4. Emergency Contact-Name/ Relationship_____ **Phone(s):** _____

Preferred Hospital: _____ _____

Parent/Guardian Signature:_____ **Date:**_____

Physician/Provider Signature: _____ **Date:**_____

The parent/guardian signature authorizes the school to share this information with school staff on a "need to know" basis. In the event of an emergency, care will be initiated, and parents will be contacted.