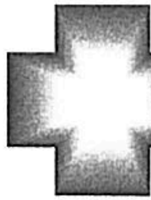


Emergency Care Plan

ALLERGY & ANAPHYLAXIS

Environmental – Food - Medicinal

Student: ______________________ Grade:____________ DOB: ___________ School Year: ____________

Asthmatic: ❑ Yes ❑ No (increased risk for severe reaction) Allergen(s): ______________________________

Mother: ____________________________ MCell #: _________ MHome #: _______ MWork #: _______

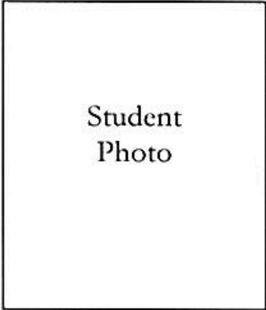
Father: ____________________________ FCell #: _________ FHome #: _______ FWork #: _______

Emergency Contact: ________________________ Relationship: ____________ Phone: ____________

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- **MOUTH** Itching & swelling of lips, tongue or mouth, mouth "feels hot"
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- **LUNG** Shortness of breath, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

The severity of symptoms can change quickly –
It is important that treatment is give immediately.



TREATMENT: Rinse contact area with water if appropriate

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms
Antihistamine ordered: ❑ Yes ❑ No Give ________ Antihistamine per provider's orders

Call parent/guardian ❑ Yes ❑ No
Epinephrine ordered: ❑ Yes ❑ No Special instructions: ______________________________

IF INGESTION OR SUSPECTED INGESTION OF ALLERGEN OCCURS, SYMPTOMS ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.
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 other students is present.

Healthcare Provider: ______________________________ Phone: ________________

Written by: ________________________________ Date: ________________

Parent/Guardian Signature to share this plan with Provider and School Staff: ____________________

This plan is in effect for the current school year and summer school as needed. Revised 7/15

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the Parent or Guardian:

I request that my child ______________________________ (Grade Level ___________) receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian): ____

Telephone: Home ________________ Work ________________ Date ________________

B. To be completed by the Private Healthcare Provider:

I request that my patient, as listed below, receive the following medication:

Name of Student ______________________________________DOB ________________

Diagnosis: ____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Possible Side Effects and Adverse Reactions (if any):

Healthcare Provider's Signature ___________________________ Date:________________

Address: ____ Phone: ______________

*Medication must be in original pharmacy labeled container with specific orders and name of medication.
*Medication and refills must be brought to school by parent, guardian or responsible adult.

This medication order is valid for the current school year and summer school as needed.

Self-Medication Release on reverse side.

SELF-MEDICATION RELEASE FORM

Student Name: ______________________________ Date: ________________

This student has been instructed in the proper use of the following medication procedures:

____

____

____

____

The Healthcare Provider and Parent signatures below indicate a request that this student be permitted to carry the medication on his/her person or to keep same in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

Healthcare Provider's Signature ____

Parent/Guardian's Signature ____

**** This form must be completed in addition to the routine district medication form for those students who request permission to carry their own Medication on campus or keep this medication in a P.E. locker.

Asthma Action Plan

Date Completed		
Name	Date of Birth	Grade/Teacher
Health Care Provider	Health Care Provider's Office Phone	Medical Record Number
Parent/Guardian	Phone	Alternate Phone
Parent/Guardian/Alternate Emergency Contact	Phone	Alternate Phone

DIAGNOSIS OF ASTHMA SEVERITY

☐ Intermittent ☐ Persistent [◯ Mild ◯ Moderate ◯ Severe]

ASTHMA TRIGGERS (Things That Make Asthma Worse)

☐ Smoke ☐ Colds ☐ Exercise ☐ Animals ☐ Dust ☐ Food
☐ Weather ☐ Odors ☐ Pollen ☐ Other ____________

GREEN ZONE: GO!

Take These **DAILY CONTROLLER MEDICINES (PREVENTION)** Medicines **EVERY DAY**

You have ALL of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

☐ No daily controller medicines required

☐ Daily controller medicine(s):____________________

☐ ____________________

Take _____ puff(s) or _____ tablet(s) _____ daily.

☐ For asthma with exercise, ADD: ____________________.

_______ puffs with spacer _______ minutes before exercise

ALWAYS RINSE YOUR MOUTH AFTER USING YOUR DAILY INHALED MEDICINE.

YELLOW ZONE: CAUTION!

Continue **DAILY CONTROLLER MEDICINES** and **ADD QUICK-RELIEF** Medicines

You have ANY of these:

- Cough or mild wheeze
- Tight chest
- Shortness of breath
- Problems sleeping, working, or playing

Take daily controller medicine if ordered and add this quick-relief medicine when you have breathing problems:

☐ ____________________ inhaler _____ mcg

Take _____ puffs every _____ hours, *if needed*. Always use a spacer, some children may need a mask.

☐ ____________________ nebulizer _____ mg /_____ ml

Take a ____________________ nebulizer treatment every _____ hours, *if needed*.

☐ Other ____________________

If quick-relief medicine does not HELP within _____ minutes, take it again and CALL your Health Care Provider

If using quick-relief medicine more than _____ times in _____ hours, CALL your Health Care Provider

IF IN THE YELLOW ZONE MORE THAN 24 HOURS, CALL HEALTH CARE PROVIDER.

RED ZONE: EMERGENCY!

Continue **DAILY CONTROLLER MEDICINES** and **QUICK-RELIEF** Medicines and **GET HELP!**

You have ANY of these:

- Very short of breath
- Medicine is not helping
- Breathing is fast and hard
- Nose wide open, ribs showing, can't talk well
- Lips or fingernails are grey or bluish

☐ ____________________ inhaler _____ mcg

Take _____ puffs every _____ hours, *if needed*. Always use a spacer, some children may need a mask.

☐ ____________________ nebulizer _____ mg /_____ ml

Take a ____________________ nebulizer treatment every _____ hours, *if needed*.

☐ Other ____________________

CALL HEALTH CARE PROVIDER AGAIN WHILE GIVING QUICK-RELIEF MEDICINE. If health care provider cannot be contacted, CALL 911 FOR AN AMBULANCE OR GO DIRECTLY TO THE EMERGENCY DEPARTMENT!

REQUIRED PERMISSIONS FOR ALL MEDICATION USE AT SCHOOL

Health Care Provider Permission: I request this plan to be followed as written. This plan is valid for the school year __________ – __________.

Signature ____________________ Date __________

Parent/Guardian Permission: I give consent for the school nurse to give the medications listed on this plan or for trained school staff to assist my child to take them after review by the school nurse. This plan will be shared with school staff who care for my child.

Signature ____________________ Date __________

OPTIONAL PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE AT SCHOOL

Health Care Provider Independent Carry and Use Permission: I attest that this student has demonstrated to me that they can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature ____________________ Date __________

Parent/Guardian Independent Carry and Use Permission (If Ordered by Provider Above): I agree my child can self-administer this rescue medication effectively and may carry and use this medication independently at school with no supervision by school personnel.

Signature ____________________ Date __________

COPY FOR PATIENT