

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

<u>Symptoms</u>	<u>Give Checked Medication</u> (to be determined by provider authorizing treatment)	
• If food allergen ingested, but <i>no symptoms</i>	☐ 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®)
☐ Epinephrine 2 mg (Neffy Nasal Spray) ☐ Epinephrine 1 mg (Neffy Nasal Spray)

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.