



ALLERGY EMERGENCY CARE PLAN

Name: _____ Grade: _____ Age: _____ Date of Birth: _____

School _____ Homeroom Teacher: _____ Room: _____

Parent/Caregiver Name: _____ Phone (home): _____ (cell) _____

Address: _____ Phone (work): _____

Attach Student Emergency Card for additional emergency contacts.

Health Care Provider Treating Student for Allergy: _____ Ph: _____

To provide assistance to a pupil experiencing an allergic reaction:

1. Type of allergy: _____	<u>ACTIONS TO TAKE (Do this)</u>
2. Identify the triggers which start an allergic reaction: _____	Stay calm.
3. Possible allergic signs: _____	Stay with the student and call for help.
OTHER: _____	*Give medication (if prescribed).
	Name of med: _____
	How to give: _____
	Amount: _____
	When to give/repeat: _____
	Location of med: _____
	OTHER: _____
	Notify parents/guardian, and document what happened in child's file.
	*By law a completed and signed Medication Form must be on file at the school before medication can be administered at school.

CALL 911 if student has

- Difficulty breathing or noisy breathing
- Tightness of chest
- Swelling of tongue, eyes, or lips
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- A wheeze or persistent cough
- Loss of consciousness and/or collapse
- Vomiting, stomach cramps, or diarrhea
- Blue discoloration of lips or fingernails
- Become pale and floppy (young children)

Administer CPR if breathing stops! Continue until paramedics arrive!

I authorize school personnel to implement this Allergy Emergency Plan as described.

Health Care Provider Signature

Date

Doy mi consentimiento para que las autoridades escolares tomen la acción apropiada para la seguridad y bienestar de mi hijo/a. Doy mi consentimiento para que las autoridades escolares se comuniquen con el médico de mi hijo/a, cuando sea necesario. Mi hijo/a no necesita los servicios.

Firma del padre de familia o encargado

Fecha