



To Be Completed by the Health Care Provider

ALLERGY EMERGENCY CARE PLAN

San Francisco Unified School District
Student Support Services
1515 Quintara Street
San Francisco, CA 94116-1273
Tel: 415.242.2615 | Fax: 415.242.2618

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:

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

I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the authorized health care provider when necessary. My child does not need services.

Parent/Caregiver Signature Date

Available @ <http://www.healthiersf.org/Forms/index.html>