STUDENT PHOTO

ALLERGY EMERGENCY CARE PLAN

For School Use Only
Location of Medication: _____

San Francisco Unified School Distirct
Student, Family, and Community Support Department
School Health Programs
1515 Quintara Street
San Francisco, CA 94116-1273
Tel: 415.242.2615 | Fax: 415.242.2618

TO BE COMPLETED BY PARENT/CAREGIVER

Student Name	*DOB*	*School*	*Grade*	*Homeroom Teacher*	*Room*

Parent/Caregiver Name	*Home Phone*	*Cell Phone*	*Email*

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Type(s) of Allergy(ies)	*Name of Health Care Provider*	*Phone*

FOR **ANY** OF THE FOLLOWING

SEVERE SYMPTOMS

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if there are no symptoms.

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting or severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION
of mild or severe symptoms from different body areas.

- ☐ **INJECT EPINEPHRINE AUTO-INJECTOR IMMEDIATELY**
- ☐ **Call 911**
- ☐ Alert parents/caregivers
- ☐ If symptoms do not improve, or symptoms return, give a second dose of Epinephrine 5 minutes after first dose
- ☐ Administer CPR if breathing stops

NOTE: WHEN IN DOUBT, GIVE EPINEPHRINE.

MILD SYMPTOMS

NOSE – Itchy, runny

SKIN – Rash, itchy

MOUTH – Itchy

- ☐ **Give:**

_____
(Medication)

- ☐ **Stay with student**
- ☐ **Watch student closely for changes**
- ☐ **If symptoms worsen, GIVE EPINEPHRINE**
- ☐ **Other**_____

_____

I authorize school personnel to implement this Allergy Emergency Plan as described.
I have completed a current (within this school year) medication form FOR EACH medication to be given.

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.

Firma del padre de familia o encargado	*Fecha*

Notify parent/guardian and document about what happened in the First Aid and Medication Logs.

***By law, a completed and signed current (within this school year) Medication Form must be on file at the school before medication can be administered at school.**

GRAPHICS ADAPTED FROM FOOD ALLERGY RESEARCH & EDUCATION (FARE)