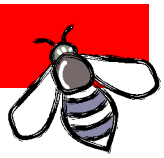
# ANNVILLE-CLEONA SCHOOL DISTRICT

# Emergency Care Plan

## SEVERE ALLERGIES



Student Photo

Student: _____ Grade: _____ DOB: _____

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

Severity of reaction(s): _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

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

- **MOUTH** Itching & swelling of lips, tongue or mouth
- **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 :** **(If Bee Sting)** Remove stinger if visible, apply ice to area. Rinse contact area with water.

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms

**Benadryl ordered:** ❑ **Yes** ❑ **No** **Dose:** _____

Call school nurse. Call parent/guardian if off school grounds.

**Epinephrine ordered:** ❑ **Yes** ❑ **No** **Dose:** _____ **Self Carry:** ❑ **Yes** ❑ **No**

**Other (inhaler-bronchodilator if asthmatic):** _____

**IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING 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 signature below indicates student has authorization to carry epinephrine auto injector with permission of the school nurse**

Health Care Provider signature: _____

Parent/Guardian Signature: _____ Date: _____

*This plan is in effect for the current school year and summer school as needed.*