SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS

EMERGENCY CARE PLAN: ENVIRONMENTAL/CONTACT ALLERGY/FOOD/BEE STING

To be completed by Parent

Student_____________________________Grade____Teacher/HR__________________DOB_____________

Asthmatic: ___yes* ___no *increased risk for severe reaction Insurance; ___________________________

Mother's Name: ________________________Home#______________Work#____________Cell____________

Father's Name_________________________Home#______________Work#____________Cell_____________

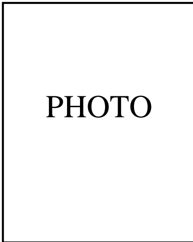
Emergency Contact:____________________________Relationship_________________Phone____________

I give permission to share this plan with physician and school staff. I agree with the Health Care Provider's orders as outlined below:

Parent signature____Date______________________________

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

(Highlighted indicates previous response by the student)



- **MOUTH** itching & swelling of lips, tongue. or mouth
- **THROAT** itching and/or a sense of tightness in the throat, hoarseness and hacking cough
- **SKIN** hives, itchy rash, and/or swelling about the face or extremities
- **GUT** nausea, abdominal cramps, and/or vomiting
- **LUNG** shortness of breath, repetitive coughing and/or wheezing
- **HEART** "THREADY" PULSE, "PASSING-OUT"

The severity of the symptoms can change quickly. It is important that treatment is given immediately.

To be completed by Health Care Provider

Allergens: (Please list) ____

ACTION:

If **ingestion is suspected and/or the only symptom(s)** are: ______________________________________

Give____**IMMEDIATELY.**

Medication(s)/dose/route

If **the following symptom(s)** develop: ____,

Give____**IMMEDIATELY.**

Medication(s)/dose/route

Self-Administer attestation:

I attest that this student has demonstrated to me that they can self-administer the medication (s) listed above safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medication listed above. Yes ______ No ______

Health Care Provider ___________________________________Phone___________________FAX______________

Printed name

Health Care Provider Signature____ Date__________________________

Information for Staff:

If symptoms or suspected contact occur, follow plan, then contact school nurse at _________________ and parent immediately.

If **Epi-Pen/Epi-Pen Jr**., **Twinject 0.3mg / Twinject 0.15 mg** is administered, **call 911**. It provides a 20 minute response window. The student may experience an increased heart rate. This is normal. A staff member should accompany student to ER if the parent/emergency contact cannot be reached.

This plan is in effect for the current school year.

Please return to ___________________________________Phone #___________________FAX________________

IF EPI-PEN IS ADMINISTERED COMPLETE BACK OF FORM AND SEND TO ER WITH STUDENT. M3 6/17

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STUDENT NAME____

Circumstances leading to administration of Epi-Pen____

____

____

____

____

____

CIRCLE ONE: Epi-Pen, Epi-Pen Jr. , Twinject 0.3mg, Twinject 0.15 mg, Auvi-Q 0.15 mg, Auvi-Q 0.3 mg given.

DATE:______________________ **TIME**__________________

LOCATION: Identify the area where Epi Pen/Twinject/Auvi-Q was administered.

Right _________________________________ **Left** ______________________________

____

SIGNATURE OF STAFF MEMBER WHO ADMINISTERED EPI-PEN

SEND THIS FORM TO ER WITH STUDENT