



Our mission is to develop children who are confident and creative learners. We provide a rigorous curriculum and a supportive school environment that promotes high achievement, encourages personal growth, and meets the unique needs of each child.

SPECIAL SERVICES DEPARTMENT

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EMERGENCY HEALTH CARE PLAN – ALLERGIC REACTION TO FOOD/SUBSTANCE
(WITH EPIPEN)

Effective School Year: 20 _____ to 20_____ Today’s Date: _____

Student’s Name: _____ Date of Birth: _____ Grade: _____

Allergy to: _____

Physician’s name and phone #: _____

Parent/Guardian #1 name and #: _____

Parent/Guardian #2 name and #: _____

ALLERGIC REACTION

Description: A dramatic sudden hypersensitive reaction of the body that normally occurs within seconds/minutes of ingestion/exposure to the allergen

IF YOU SEE THIS:	DO THIS:
<ul style="list-style-type: none"> • Mild reaction: itching of the skin, raised rash, localized swelling. May progress to more. • Severe reaction: <ul style="list-style-type: none"> ○ Mouth- itching/swelling of the lips and tongue ○ Throat – sudden dry, hacking cough, hoarseness, constricted feeling in the throat/chest ○ Skin – hives, itchy rash, flushed skin, sweating, swelling about the face/extremities ○ Lungs – difficulty breathing, wheezing, may progress to blue color of lips or nails ○ Heart – rapid, thread pulse, passing out ○ GI- abdominal pain, nausea or vomiting ○ Mental status – anxiety/sense of uneasiness, fright confusion 	<ul style="list-style-type: none"> • Mild reaction: <ul style="list-style-type: none"> ○ Remove causative agent. ○ Initiate doctor’s order of PRN prescribed medication: (med/dosage/route): _____ ○ Reassess student after 20-30 minutes of above medication given. ○ If skin irritation, cleanse with soap and water and apply ice • Severe reaction: <ul style="list-style-type: none"> ○ Identify symptoms of anaphylaxis ○ If student self-carries epipen, administer epipen IM (dose): _____ ○ If student does NOT self-carry epipen, call 911 ○ Notify school nurse/health clerk to get epipen ○ Administer CPR if indicated ○ Do not leave the student unattended ○ Keep student warm ○ School nurse will notify principal/parent



TO BE REVIEWED AND SIGNED BY PARENT/GUARDIAN

I give permission to the school nurse/health clerk and other designated staff members of District 68 to perform and carry out the emergency care plan as outlined by this emergency health care plan. I also consent to the release of the information contained in this emergency health care plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

 Parent Signature

 Date

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER UPON REVIEW AND APPROVAL

Medication to be taken at school for this condition: _____

Does the student require an allergen-free lunch table: _____

Other medical notes: _____

 Physician signature

 Date

This form shall be effective for the current school year only, and must be renewed each subsequent school year.