Burnt Hills-Ballston Lake Central Schools

EMERGENCY CARE PLAN- FOOD ALLERGIES

SYMPTOMS OF AN ALLERGIC REACTION may include any/ all of the following::

- MOUTH Itching/ swelling of lips, tongue, or mouth; 'feels' hot;
- THROAT Itching tightness in throat, hoarseness, cough;
- SKIN Hives, itchy rash, swelling of face and/or extremities;
- STOMACH Nausea, abdominal cramps, vomiting, diarrhea;
- LUNG Shortness of Breath, repetitive cough, wheezing;
- HEART Weak 'thready' pulse, feeling faint/ passing out;

Student: _____ Grade _____ DoB _____

ALLERGENS _____ Asthmatic: Yes_____ No _____

Mother/ Guardian: _____ Home # _____ Work/ Cell #_____

Father/ Guardian: _____ Home # _____ Work/ Cell #_____

Other: _____ Relationship_____ Phone # _____

Severity of symptoms can change quickly so it is important that treatment is given immediately !

TREATMENT: Rinse mouth/ contact area with water if able/appropriate;

Benadryl (Diphenhydramine) **Ordered?** ❑ YES ❑ No (only to be given if able to swallow)

25mg tab give_____tabs PO 12.5mg (chew) tabs give _____tabs PO

12.5mg/5ml give _____mls PO

To be given: ❑ with symptoms ❑ without waiting for symptoms *(SUSPECTED INGESTION)*

Epinephrine Ordered? ❑ YES ❑ NO **Dose:** ❑ 0.3 mg IM ❑ 0.15 mg IM

To be given: ❑ with symptoms ❑ without waiting for symptoms *(SUSPECTED INGESTION)*

ADMINISTER MEDICATION AS ORDERED AND CALL 911 !!

Preferred hospital if transported: _____

Epinephrine provides a 20 min response window. After epinephrine, the student may feel dizzy and/or have an increased heart rate. This is a normal response. Students receiving epinephrine may be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent/ guardian is not present.

❑ The student should be permitted to carry their medication on their person, or leave in a locker, as we consider them responsible. He/ she has been instructed in the use of their medication. *

❑ The medication should be kept in the school nurse's office * (*Both may be checked as needed)

Healthcare Provider : _____ School Year: _____

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Providers Signature: _____ Date: _____

Plan Written by: _____ if provider orders not on ECP. Parent/ Guardian _____ Date: _____

for permission to share plan with staff as needed.