

# INDIVIDUAL EMERGENCY CARE PLAN, SEVERE ALLERGY (Food, Bees, Other)

<b>SEVERE ALLERGY TO</b> _____ <b>Other allergies</b> _____  <b>Name</b> _____ <b>D.O.B.</b> _____ <b>Teacher:</b> _____ Asthmatic?(High risk for severe reaction) <input type="checkbox"/> yes <input type="checkbox"/> no <b>Date of last reaction</b> _____ <b>Does child wear medic alert jewelry?</b> <input type="checkbox"/> yes <input type="checkbox"/> no <b>Type:</b> _____ <b>Location of rescue medication:</b> <input type="checkbox"/> office <input type="checkbox"/> backpack <input type="checkbox"/> on person <input type="checkbox"/> other _____	Place Child's Picture Here
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◆ **SIGNS OF AN ALLERGIC REACTION** ◆ If you suspect a severe allergic reaction to bees or food, immediately determine symptoms and treat the reaction as follows:

<b>Systems:</b>	<b>Symptoms(known symptoms ' X '):</b>	<b>Give Medication (X)</b>
<input type="checkbox"/> <b>MOUTH</b>	Itching & swelling of the lips, tongue, or mouth	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epipen
<input type="checkbox"/> <b>THROAT*</b>	Itching and/or a sense of tightness in the throat, hoarseness, hacking cough	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epipen
<input type="checkbox"/> <b>SKIN</b>	Hives, itchy rash, and/or swelling about the face or extremities	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epipen
<input type="checkbox"/> <b>GUT</b>	Nausea, abdominal cramps, vomiting and/or diarrhea	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epipen
<input type="checkbox"/> <b>LUNG*</b>	Shortness of breath, repetitive coughing, and/or wheezing	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epipen
<input type="checkbox"/> <b>HEART*</b>	“thready” pulse, “passing out”	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epipen
<input type="checkbox"/> <b>GENERAL</b>	Panic, sudden fatigue, chills, fear of impending doom	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epipen
<input type="checkbox"/> <b>OTHER</b>	_____	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epipen

The severity of symptoms can quickly change. \*All above symptoms can potentially progress to a life-threatening situation.

◆ **ACTION FOR MINOR REACTION** ◆

1. If only symptom(s) are: \_\_\_\_\_, give \_\_\_\_\_ medication/dose/route
2. Then call:  
 Mother \_\_\_\_\_, Father \_\_\_\_\_, or emergency contacts.  
 Dr. \_\_\_\_\_ at \_\_\_\_\_

**If condition does not improve within 10 minutes, follow steps for Major Reaction below.**

◆ **ACTION FOR MAJOR REACTION** ◆

1. If ingestion is suspected and/or symptom(s) are: \_\_\_\_\_, give \_\_\_\_\_ IMMEDIATELY!  
 \_\_\_\_\_ Medication/ dose/ route
- Then call:
2. 9-1-1 Advise 911 dispatch that the student is having a severe allergic reaction and Epipen is being administered.
3. Mother \_\_\_\_\_, Father \_\_\_\_\_, or emergency contacts.
4. Dr. \_\_\_\_\_ at \_\_\_\_\_

**DO NOT HESITATE TO CALL RESCUE SQUAD**

- ◆ Notify health office and main office on walkie-talkie #9, channel 2, via intercom or phone (388-3023, 388-4086).
- ◆ Student should remain quiet with a staff member at the location where symptoms began until Rescue Squad arrives.
- ◆ Provide Rescue Squad with copy of the Emergency Care Plan.

**EMERGENCY CONTACTS**

Name _____	Relationship _____	Name _____	Relationship _____
Home Phone _____	Work _____	Cell _____	Home Phone _____
Work _____	Cell _____	Work _____	Cell _____

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_ Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Health Aide Signature \_\_\_\_\_ Date \_\_\_\_\_

- Copies:**  Parent  Physician  Health Aide  Teacher(s)  PE  Library  Music/band  Art  Computer  Spanish  
 Cafeteria  Auxiliary  Recess Aide  Transportation (provided by parent/guardian)  Office/Principal

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 It is the parents' responsibility to notify and provide the IECP to the appropriate transportation district and after-school functions.