Blessed Sacrament School
Health Services

FOOD ALLERGY EMERGENCY CARE PLAN

Student: _____ Grade: _____ Teacher: _____ DOB: _____

Asthmatic: ☐ Yes ☐ No (increased risk for severe reaction) Allergen(s): _____

Mother: _____ Home#: _____ Work#: _____ Cell#: _____

Father: _____ Home#: _____ Work#: _____ Cell#: _____

Emergency Contact: _____ Relationship: _____ Best phone number during school hours: _____

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

- **MOUTH** Itching & swelling of lips, tongue, or mouth, mouth "feels hot"
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting and/or 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 given immediately.

STAFF MEMBERS INSTRUCTED: ☐ **Teacher** ☐ **Special Teachers** ☐ **Administration** ☐ **Support Staff**

TREATMENT: Rinse contact area with water.

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

Benadryl ordered: ☐ Yes ☐ No Give _____ Benadryl per provider's orders

Call school nurse at: **Ext. 368** or **315-463-1261** Call parent/guardian if off school grounds

Epinephrine ordered: ☐ Yes ☐ No Special Instructions: _____

IF INGESTION OR SUSPECTED INGESTION OF ALLERGEN OCCURS, SYMPTOMS ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Preferred Hospital if transported: _____

Epinephrine provides a 20-minute response window. After epinephrine, a student may feel dizzy or have 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: _____ **Phone:** _____

Written by: _____ **Date:** _____

Provider Parent/Guardian Signature (to share this plan with Provider and School Staff): _____

☐ **Copy provided to parent** ☐ **Copy sent to Healthcare**

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