

## Valley Central School District Food Allergy Emergency Health Care Plan

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Asthmatic:  Yes  No (increased risk for severe reaction) Allergen(s): \_\_\_\_\_

Mother: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Father: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Area	Symptoms	Give Checked	Medication
	If food allergen has been ingested, but <i>No Symptoms</i>	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Mouth	Itching, tingling, swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Skin	Hives, itchy rash, swelling of face, extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Throat *	Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Lung *	Shortness of breath, wheezing, repetitive cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Heart *	Weak pulse, low BP, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
Other *		<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
	If restriction is progressing give:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

\*Potentially- Life Threatening. The severity of symptoms can rapidly change

Insert Student Photo above

**STAFF MEMBERS INSTRUCTED:**  Classroom Teacher(s)  Special Area Teacher(s)  
 Administration  Support Staff

### TO BE COMPLETED BY HEALTH CARE PROVIDER

**TREATMENT:** Rinse contact area with water if appropriate

Treatment should be initiated  with symptoms  without waiting for symptoms

Medication ordered: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication ordered: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

Special instructions: \_\_\_\_\_

Call school nurse. Call parent/guardian if off school grounds.

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

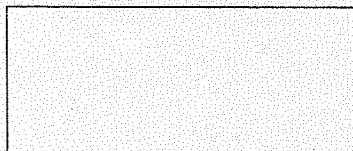
Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room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

Written by: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature to share this plan with Provider and School Staff: \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Stamp



Please see reverse side of this form->

*This plan is in effect for the current school year and summer school as needed.*

Revised 1/12

# Valley Central School District

## PROVIDER AND PARENT PERMISSIONS REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

**Directions for the Health Care Provider:** This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently use and carry their medication as required by NYS law. A provider **order** and **parent/guardian permission** is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

### Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below 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 medications checked below:

This student is diagnosed with:

- Allergy and requires Epinephrine Auto-injector
- Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- \_\_\_\_\_ which requires rapid administration of \_\_\_\_\_  
(State Diagnosis) (Medication Name)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may use and carry this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Please return to School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email: