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 *No Symptoms*	o Epinephrine	o Antihistamine
Mouth	Itching, tingling, swelling of lips, tongue, mouth	o Epinephrine	o Antihistamine
Skin	Hives, itchy rash, swelling of face, extremities	o Epinephrine	o Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	o Epinephrine	o Antihistamine
Throat *	Tightening of throat, hoarseness, hacking cough	o Epinephrine	o Antihistamine
Lung *	Shortness of breath, wheezing, repetitive cough	o Epinephrine	o Antihistamine
Heart *	Weak pulse, low BP, fainting, pale, blueness	o Epinephrine	o Antihistamine
Other *		o Epinephrine	o Antihistamine
	If restriction is progressing give:	o Epinephrine	o 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: _____

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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
- ☐ _____ (State Diagnosis) which requires rapid administration of _____ (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: