

**UNION TOWNSHIP SCHOOL DISTRICT
INDIVIDUALIZED EMERGENCY HEALTH CARE PLAN**

Student's Name _____ Date of Birth _____ Teacher _____

ALLERGY TO: _____

Asthmatic Yes [] No [] *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION MAY INCLUDE:

SYSTEMS:

- Mouth
- Throat
- Skin
- Gut
- Lung
- Heart

SYMPTOMS:

- Itching and swelling of the lips, tongue, or mouth
- Itching and/or a sense of tightness in the throat, hoarseness, and hacking
- Hives, itchy rash, and/or swelling about the face or extremities
- Nausea, abdominal cramps, vomiting, and/or diarrhea
- Shortness of breath, repetitive coughing, and/or wheezing
- "Thready" pulse, "passing out"

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

PHYSICIAN'S ORDERS

1. This student does not have the capability for self-administration.
2. Physician's order for epinephrine single-dose auto-injector: _____
3. Administer when there is contact with allergen and at first sign of _____

ACTION

1. If allergic reaction is suspected, follow physician's orders and immediately call the nurse, ext. _____ and inform her of the situation and location
2. If the nurse is in her office, she will go directly to the location, or direct that the student be sent with another adult. Never send the student alone.
3. If nurse is not located immediately, call _____ ext. _____ or _____ ext. _____ who have also been trained in treatment protocols and who will respond to location.
4. Call office ext. _____ to advise of situation
5. Calmly reassure student and stay with her/him.
6. Upon arrival, school nurse or trained designee will assess his/her needs, administer medication if needed, and immediately call 911 or rescue squad if warranted. Any student receiving epi-pen will be sent to the nearest hospital.
7. Nurse/office staff will notify parents, and covering nurse.
8. If a pupil should suffer an anaphylactic reaction and neither the school nurse or designate is available, call 911, and tell operator student may be having a severe allergic reaction.

**ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR
CANNOT BE REACHED**

I agree to indemnify and hold harmless the Union Township School District and employees from any claims arising from the administration of epinephrine to my child.

Parent/Guardian Signature _____ Date _____ Physician's Signature _____ Date _____

EMERGENCY CONTACTS

1. _____
Relation _____ Phone _____
2. _____
Relation _____ Phone _____

TRAINED STAFF MEMBERS

1. _____ Room _____
2. _____ Room _____