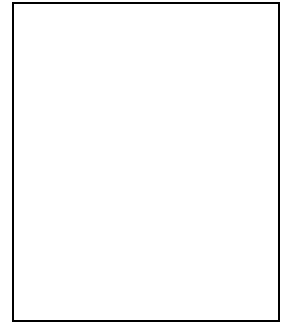


# St. Thomas More School

## INDIVIDUAL EMERGENCY HEALTH CARE PLAN SEVERE ALLERGY (FOOD, BEE, Other)

NAME\_\_\_\_\_D.O.B.\_\_\_\_\_

GRADE\_\_\_\_\_TEACHER(S)\_\_\_\_\_



SEVERE ALLERGY TO\_\_\_\_\_Other allergies\_\_\_\_\_

Asthmatic? (High risk for severe reaction) ☐ Yes ☐ No Date of Last Reaction\_\_\_\_\_

Does child wear medic alert jewelry? ☐ Yes ☐ No Type:\_\_\_\_\_

Medication:\_\_\_\_\_

**Epinephrine Dosage: Inject intramuscularly (Circle One)**

Epi-Pen Epi-Pen Jr. Twinject 0.3mg Twinject 0.15mg Auvi-Q 0.15mg Auvi-Q 0.3mg

(See reverse side for instructions)

Location of Medication ☐ Office ☐ Backpack ☐ On Person ☐ Other

**Self-Administration** My child has been instructed in the correct way to use the above medication and should be permitted to carry and use that medication by himself/herself without supervision. I give my child permission to do so. *Circle One:* YES NO

**I will provide a back-up EPI-Pen to be kept in the Health Office:** *Circle One:* YES NO

Antihistamine:\_\_\_\_\_

MEDICATION/DOSE/ROUTE

Other:\_\_\_\_\_

MEDICATION/DOSE/ROUTE

**IMPORTANT: Asthma Inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis**

# **St. Thomas More School**

## **INDIVIDUAL EMERGENCY HEALTH CARE PLAN SEVERE ALLERGY (FOOD, BEE, Other)**

### **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><u>Systems:</u></b>                  | <b><u>Symptoms (known symptoms ‘ X ’):</u></b>                               | <b><u>Give Medication (X)</u></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**

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**See page 3**

**◆Actions to be taken for minor Allergy reaction**

**◆Actions to be taken for Major Allergy reaction**

# **St. Thomas More School**

## **INDIVIDUAL EMERGENCY HEALTH CARE PLAN SEVERE ALLERGY (FOOD, BEE, Other)**

### **◆ 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**

- ◆ 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.

# St. Thomas More School

## INDIVIDUAL EMERGENCY HEALTH CARE PLAN SEVERE ALLERGY (FOOD, BEE, Other)

### ◆ EMERGENCY CONTACTS

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

3. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

4. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

.....

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

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

School Office \_\_\_\_\_ 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

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