ST. PATRICK CATHOLIC SCHOOL EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION - ALLERGY

CHILD'S PHOTO

NAME: _____ **TEACHER/GRADE**_____

ALLERGY TO: _____

Asthma ○ **Yes (higher risk for severe reaction)** ○ **No** **WEIGHT**____**LBS.** **D.O.B:**____/____/____

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring (see below)
- Additional medications:
- Antihistamine
- Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis) → Use Epinephrine.

When in doubt, use epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY

Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**
☐ **If checked, give epinephrine before symptoms if the allergen was definitely eaten.**

MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): _____

ANTIHISTAMINE (BRAND AND DOSE): _____

Other (e.g., inhaler-bronchodilator if asthma): _____

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

CONTACTS: CALL 911 **HOME PHONE:** _____

Parent/Guardian: _____ **Work:** _____ **Cell:** _____

Parent/Guardian: _____ **Work:** _____ **Cell:** _____

Name/Relationship: _____ **Home:** _____ **Cell:** _____

Name/Relationship: _____ **Home:** _____ **Cell:** _____

_____Student may self-carry epinephrine _____ Student may self-administer epinephrine _____Student may self-carry inhaler

Licensed Healthcare Provider Signature: _____ **Phone:** _____ **Date:** _____

I hereby authorize St. Patrick Catholic School employees/volunteers to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child_____ according to the instructions of my physician. I further understand that my physician's order for medication must be renewed annually or at any time the medication is changed. I will assume the responsibility of bringing the medication to the school or assign an adult designee to do so. I do not hold St. Patrick Catholic School or the person administering the medication liable if any adverse reactions and/or side effects should occur, or for any adverse reactions/side effects that may occur as a result of my child's self-administration of medication as ordered above. I also hereby authorize St. Patrick Catholic School staff members to disclose my child's protected health information to non-employee volunteers at the school or at school events or field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian Signature: _____ **Date:** _____