the treehouse

Life Threatening Allergy
EMERGENCY HEALTH CARE PLAN

Name:_____ **D.O.B.:**_____ **Grade/Teacher:**_____

Allergy To:_____

Delegate: *In the event of anaphylaxis, I give permission for a delegate (a trained school employee other than nurse) to administer epinephrine via a pre-filled, auto-injector to my child.* _____*Yes* _____*No (please initial)*

♦STEP 1: TREATMENT♦

SYMPTOMS		GIVE CHECKED MEDICATION (**To be determine by physician authorizing treatment)		
If the allergen has been ingested/ contacted but no symptoms		□Epinephrine	**or**	□Antihistamine
MOUTH	Itching and swelling of the lips, tongue or mouth	□Epinephrine	**or**	□Antihistamine
SKIN	Hives, itchy rash, swelling of the face or extremities	□Epinephrine	**or**	□Antihistamine
STOMACH	Nausea, abdominal cramps, vomiting, diarrhea	□Epinephrine	**or**	□Antihistamine
THROAT*	Tightening of, hoarseness, hacking cough	□Epinephrine	**or**	□Antihistamine
LUNG*	Shortness of breath, repetitive coughing, wheezing	□Epinephrine	**or**	□Antihistamine
HEART*	Thready pulse, low blood pressure, fainting, pale, blueness	□Epinephrine	**or**	□Antihistamine
OTHER_____		□Epinephrine	**or**	□Antihistamine
If a reaction is progressing (Several of the above areas affected), give		□Epinephrine	**or**	□Antihistamine

The severity of these symptoms can quickly change. *Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) **EpiPen®** **EpiPenJR®** **Auvi-Q 0.3mg** **Auvi-Q 0.15mg**

Antihistamine: give_____ **Other**_____
Medication / Dose / Route **Medication / Dose / Route**

I have certified that this child is capable of self administering this medication ____ **NO** ____ **YES**

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

♦STEP 2: EMERGENCY CALLS♦

1. CALL 9-1-1: State that an allergic reaction has been treated, and additional epinephrine may be needed

2. CALL Mother:_____ **Father**: _____

EVEN IF PARENTS OR DOCTORS CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY

I hereby request and authorize appropriate Bernards Township Public School employees to administer prescribed medication as directed by the undersigned licensed healthcare provider. I grant permission for Bernards Township Public School employees to exchange information with my child's healthcare provider as deemed necessary.

Parent's Signature _____ Date_____

Physician Signature _____ Date_____

Nurses Signature _____ Date_____

PHYSICIAN STAMP
(Must be present for plan to be valid)