EMERGENCY PLAN FOR STUDENTS WITH SEVERE ALLERGIC REACTIONS

Student's Name________________________________Grade_____School Year________
Parent/Guardian______________________________Home #___________Work#________
Physician___________________________________Phone#______________________
Family member or friend aware of child's condition
Name_______________________________________Phone#______________________

My child is at risk for a life-threatening allergic reaction: ____ Yes ____ No

My Child has an allergic reaction to:
Bees Latex Food (Please specify which food) ______________________________
Other ______________________________

Please check circumstances which reaction could occur:
______skin contact _____ingestion(eating allergen) _____inhalation (breathing allergen)
-My child's allergy was identifies through allergy testing. ____yes ____ no
-My child had his/her reaction on the following date: _______________

-My child had the following symptoms during the reaction: (circle appropriate information)

Red, watery eyes Shortness of breath Coughing Swelling Nausea/Vomiting

Runny nose Tightening of throat Hives Dizziness Other ______________________

If an allergic reaction would occur at school, personnel will administer first aid (remove stinger, apply ice, observe for 15 minutes and record side effects). You will be notified of the incident immediately. Please indicate which further treatment a health care provider is recommending for your child:

________Administer medication – Name and dosage____________________________
________Call 911 Immediately ____________________________

****Please note that 911 will be called if an Epipen is given or if your child is demonstrating symptoms of a systemic allergic reaction****

I hereby give permission for designated school staff to give this medication to my child according to the directions stated above and for the school nurse to contact my child's physician if necessary.

I further agree to hold harmless Sacred Heart Parish School *Board of Education, administration, and all employees and agents who are acting within the scope of their duties harmless in any and all claims arising form the administration of this medication, to policy at school.*

I agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

Parent signature____________________________________Date___________
School Nurse Signature______________________________Date___________
Physician Signature ________________________________Date ___________