SEGUIN INDEPENDENT SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

EMERGENCY HEALTH CARE PLAN

Allergic Emergency

Student::_____ Grade:_____ DOB: _____

Asthmatic: ___Yes ___ No (increased risk for severe reactions) Allergens: _____

Mother:_____Home #:_____ Work #_____ Cell #: _____

Father:_____ Home #:_____ Work #_____ Cell #: _____

Emergency Contact:_____ Relationship:_____ Phone:_____

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THE FOLLOWING:

✓ MOUTH	Itching and swelling of lips, tongue or mouth, mouth "feels hot"
✓ THROAT	Itching, tightness in throat, hoarseness, cough
✓ SKIN	Hives, itchy rash, swelling of face and extremities
✓ STOMACH	Nausea, abdominal cramps, vomiting, diarrhea
✓ LUNG	Shortness of breath, repetitive cough, wheezing
✓ HEART	"Thready pulse," "passing out"

THE SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY
- IT IS IMPORTANT THAT TREATMENT IS GIVEN IMMEDIATELY.

STAFF MEMBERS INSTRUCTED: ___Classroom Teacher(s) ___Special Area Teacher(s) ___Administration
___Support Staff ___Transportation Staff

TREATMENT: Rinse area with water if appropriate.

Treatment should be initiated: ___with symptoms ___without waiting for symptoms
Benadryl ordered: ___Yes ___No Give _____ (dose) Benadryl per provider's orders

Call School Nurse. Call parent / guardian if off school grounds.

Epinephrine ordered: ___Yes ___No Special Instructions:_____

IF INGESTION OR SUSPECTED INGESTION OF ALLERGEN OCCURS, SYMPTOMS ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Child will be transported to Guadalupe Valley Hospital. Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: ___Medication available on bus ___Medication is NOT available on bus ___Does not ride bus

Special instructions: _____

Healthcare Provider:_____ Phone: _____

Written by:_____ Date:_____

___ Copy provided to Parent ___ Copy sent to the Healthcare Provider

Parent/Guardian Signature:_____ Date:_____

Doctor's/Health Care Provider Signature:_____ Date: _____

This plan is in effect for the current school year and summer school as needed.