Northampton Area School District

EMERGENCY HEALTH CARE PLAN: ALLERGIC REACTION

SCHOOL: ______________________

Student: ____________________ Grade: ______________ Date: ______________

Allergy To: ____

Asthmatic: _____Yes (High risk for severe reaction) _____No

Parent/Guardian___________________ **Phone:** _______________ **Phone:** _____________

Parent/Guardian___________________ **Phone:** _______________ **Phone:** _____________

Other Emergency Contact:_________________________________ **Phone:** _____________

Physician: ____ **Phone:** _____________

Signs of an allergic reaction include:

MOUTH	itching and swelling of the lips, tongue or mouth
THROAT	itching and/or a sense of tightness in the throat, hoarseness, cough
SKIN	hives, itchy rash, and/or swelling about the face or extremities
STOMACH	nausea, abdominal cramps, vomiting and/or diarrhea
LUNG	shortness of breath, repetitive coughing, and/or wheezing
HEART	"thready pulse", "passing out"

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation!

WHAT TO DO:

1. If ingestion/exposure is suspected, administer ________________________________

   ________________________________ **immediately !**

   Location of Meds: ________________________________

2. Call: Rescue Squad @ 911

3. Call Parents

4. If on field trip, call school after steps 1 – 3 above!

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

I give my permission for this information to be shared with adults at NASD on a need to know basis. This health care plan will be in effect for the current school year. I understand that it is my responsibility to notify the Health Services office whenever there is a change in my child's health status or care.

________________________ ________ ________________________ ________

Parent Signature Date Physician Signature Date

<u>TRAINED STAFF MEMBERS</u>

1. ________________ ________ ________________

   NAME ROOM # SIGNATURE

2. ________________ ________ ________________

   NAME ROOM # SIGNATURE

________________ School Nurse