EMERGENCY CARE PLAN

St. John the Baptist Diocesan High School
Health Office
Allergy/Anaphylaxis Care Plan/ Medication Authorization

Place picture here

Student's Name: _____ DOB: _____ Teacher_____

ALLERGY TO: _____

Asthmatic: Yes*___ No___ *Higher risk for severe reaction

Step 1: Treatment

Symptoms:		**Give checked medication**:**	
If a food allergen has been ingested, but no symptoms:		__ Epinephrine	__Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	__ Epinephrine	__Antihistamine
Throat!	Tightening of throat, hoarseness, hacking cough	__ Epinephrine	__Antihistamine
Lung!	Shortness of breath, repetitive coughing, wheezing	__ Epinephrine	__ Antihistamine
Heart!	Thready pulse, low blood pressure, fainting, pale, blueness	__ Epinephrine	__ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	__ Epinephrine	__ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	__ Epinephrine	__ Antihistamine
Other!	_____	__ Epinephrine	__ Antihistamine
If reaction is progressing (several of the above areas affected), give:		__ Epinephrine	__ Antihistamine

The severity of the symptoms can quickly change. ! Potentially life threatening – ACT FAST!

NOTE: Asthma inhalers and/or antihistamines CANNOT be depended on in anaphylaxis.

DOSAGE

Epinephrine: give _____
medication/dose/route/frequency

Antihistamine: give_____
medication/dose/route/frequency

Other (please specify): give _____
medication/dose/route/frequency

Possible side effects or adverse reactions (if any): _____

Physician Signature _____ Date_____
Physician Phone Number _____

Parent/Guardian Signature _____ Date _____

STEP 2: EMERGENCY CALLS

1st - Call 911-tell rescue squad epinephrine has been given (note time given); request ambulance with epinephrine.

2nd - Call Parent/Guardian: Name _____ phone: _____

Emergency contacts: _____ phone: _____

Name/Relationship: _____ phone: _____

This plan is in effect for the current school year and summer school as needed. Revised 5/2020