EMERGENCY HEALTH CARE PLAN
WESTON PUBLIC SCHOOLS

STUDENT'S NAME_____ DATE OF BIRTH _____

TEACHER'S NAME_____ GRADE _____

STUDENT'S ADDRESS _____ TELEPHONE _____

PHYSICIAN'S NAME _____ PHYSICIAN'S PHONE _____

SPECIFIC FOOD ALLERGY _____ DATE DIAGNOSED BY PHYSICIAN _____

HISTORY OF ANAPHYLAXIS: ☐ YES ☐ NO ASTHMA: ☐ YES ☐ NO

IF STUDENT INGESTS OR THINKS HE/SHE HAS INGESTED THE ABOVE NAMED FOOD:

#Order	*Additional Comment*	*Circle or Complete Option As Appropriate*
____	_____	Observe student for symptoms of anaphylaxis
____	_____	Administer adrenaline before symptoms occur – EpiPen Jr. Adult
____	_____	Administer adrenaline if symptoms occur -- EpiPen Jr. Adult
____	_____	Administer Benadryl ____ Tsp or Atarax ___ Tsp Swish & Swallow
____	_____	Administer _____
____	_____	call 9-1-1 and transport by ambulance to the emergency room

_____ _____
Date Physician's Signature

PARENT – I have reviewed and agree with the above protocol. I authorize communication between the prescribing Physician and school nurse necessary for the safe implementation of this treatment protocol so long as it is in effect.

_____ _____
Date Parents Signature

Symptoms of anaphylaxis

- **Chest tightness, cough, shortness of breath, wheezing**
- **Tightness in throat, difficulty swallowing, hoarseness**
- **Swelling of lips, tongue, throat**
- **Itchy mouth, itchy skin**
- **Hives or swelling**
- **Stomach cramps, vomiting or diarrhea**
- **Dizziness or faintness**

Emergency Contacts

1. _____ _____
Name **Phone #**
Relationship:_____

2. _____ _____
Name **Phone #**
Relationship: _____

3. _____ _____
Name **Phone #**
Relationship: