SCHOOL EMERGENCY PLAN – INSECT STING / FOOD ALLERGY

Health Care Provider to complete all areas in italics above dotted line

Student: _____ *Birth date:* _____

Allergy: _____

STUDENT PHOTO

In this student, an insect sting or ingestion of an allergy producing food(s), even in small amounts, could lead to a severe, life-threatening reaction. Any suspected or known reaction requires close monitoring and immediate treatment of symptoms as set forth below.

DO NOT HESITATE TO GIVE EMERGENCY TREATMENT IF UNCERTAIN OF SYMPTOMS OR SEVERITY

SEVERE SYMPTOMS (one or more):

LUNG: short of breath, wheeze, repetitive cough
HEART: pale, blue, faint, weak pulse, confused
THROAT: tight, hoarse, trouble breathing or swallowing
MOUTH: swelling of tongue or lips
SKIN: many hives over body, facial swelling
GUT: vomiting, cramping pain, nausea

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1. ***INJECT EPINEPHRINE IMMEDIATELY*** ***(outer thigh)***

   *Type*_____, *Dose* _____
   (See label on auto-injector for directions)

2. *Always call 911 after giving epinephrine.*
3. *Have child lie on back with feet raised.*
4. *Stay with student and monitor closely.*
5. *Alert parents.*
6. *For worsening symptoms, give second dose after 5 minutes; for persistent symptoms, give second dose of epinephrine after 10 minutes.*

MILD SYMPTOMS ONLY (one or more):

MOUTH: itchy mouth
SKIN: a few hives* around mouth/face; mild itch
GUT: mild nausea/discomfort
*raised, itchy bumps that appear suddenly

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1. *GIVE oral* ***ANTIHISTAMINE:***

   *Type*_____, *Dose* _____
2. *Contact parent to pick up student. Monitor closely until parent arrives.*
3. ***IF SYMPTOMS PROGRESS, INJECT EPINEPHRINE:*** (see above)

This student is at very high risk of experiencing a severe reaction, therefore:

☐ *Give EPINEPHRINE immediately for any symptom following an insect sting or ingestion of* _____.

☐ *Give EPINEPHRINE immediately, even if no symptoms, following an insect sting or ingestion of* _____.

☐ *This student also has* ***asthma****. In addition to emergency medications:*

Give rescue inhaler (type)_____***; (dose)*** _____ ***for any symptoms.***

MEDICATION(S) MUST BE AVAILABLE TO STUDENT AT ALL TIMES, INCLUDING OFF CAMPUS ACTIVITES

_____ _____ _____ _____
Signature of Health Care Provider ***Date*** ***Phone*** ***Hospital***

I give my permission to the nurse or delegate(s) to administer medication to my child and to follow the written instructions provided by the Health Care Provider as indicated on my child's School Emergency Plan - Food Allergy. I also give my permission to the school nurse to communicate with my child's Health Care Provider regarding health and safety in the school environment as it relates to his/her food allergies.

_____ _____ _____ _____
Signature of Parent/Legal Guardian Date Phone Alternate

_____ _____
Emergency contact name / relationship / phone Emergency contact name / relationship / phone

This form is approved by UW-Health and Dean Pediatric Allergists