

Date Plan Developed: _____

RIVERSIDE CHRISTIAN SCHOOL

SEVERE ALLERGY to (Specify)

Emergency Care Plan

Never send student with any allergic symptoms anywhere alone!!

Student Name: _____ DOB: _____

Asthmatic _____ Yes, this student is HIGH RISK for severe reaction. _____ No

Parent/Guardian: _____ Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Home Phone: _____ Work Phone: _____

Physician: _____ Phone: _____

Current Medications:

Allergies:

SYMPTOMS and SIGNS of an ALLERGIC REACTION

Systems	Symptoms
	Severity of symptoms can change quickly and rapidly progress to a life threatening situation!!!!!!
Mental	States feel "scared, something bad is going to happen"
Mouth	Itching and swelling of the lips, tongue, or mouth
Throat	Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
Skin	Hives, itchy rash, and/or swelling about the face or extremities
Gut	Nausea, stomach cramps, vomiting, and/or diarrhea
Lung	Shortness of breath, repetitive coughing, and or wheezing
Heart	Signs of shock, passing out

IF YOU SEE THIS	DO THIS	TIME Initial
ANY OF THE ABOVE SIGNS AND SYMPTOMS Following exposure to:	Never send student anywhere alone!!! If unable to go to office, have meds brought to student. Give Benadryl. (Specific to student) Dose: _____ CALL PARENT If possible, adult stay with student, reassure, and watch student closely for ANY PROGRESSION OF SYMPTOMS.	
INCREASE OF SYMPTOMS AND/OR SHORTNESS OF BREATH	GIVE EPI-PEN IN OUTER THIGH Epi-Pen is located in _____ CALL 911	
BREATHING STOPS	Begin CPR/RESCUE BREATHING Elevate Legs	

Note time of arrival and departure of ambulance; complete this form, initial, and send a copy of form with the ambulance.

The following staff members are trained to deal with an emergency, and initiate the appropriate procedures:

1. _____ 2. _____ 3. _____

RN Signature

Date

PMD/Provider Signature

Date

Parent/Guardian Signature

Date