Valley Central School District
Food Allergy Emergency Health Care Plan

Student: ______________________________ Grade: ________ DOB: __________

Asthmatic: ❑ Yes ❑ No (increased risk for severe reaction) **Allergen(s):** ______________________

Mother: ______________________ MHome #: __________ MWork #: __________ MCell #: __________

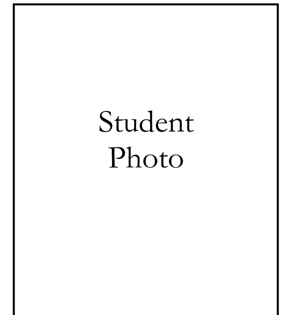
Father: ______________________ FHome #: __________ FWork #: __________ FCell #: __________

Emergency Contact: ____________________ Relationship: ____________ Phone: ____________

SYMPTOMS OF AN ALLLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- **MOUTH** Itching & swelling of lips, tongue or mouth, mouth "feels hot"
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- **LUNG** Shortness of breath, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

The severity of symptoms can change quickly –
It is important that treatment is give immediately.



STAFF MEMBERS INSTRUCTED: ❑ Classroom Teacher(s) ❑ Special Area Teacher(s) ❑ Administration ❑ Support Staff

TO BE COMPLETED BY HEALTH CARE PROVIDER

TREATMENT: Rinse contact area with water if appropriate

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms

Medication ordered: ______________ Dose: ____________ Route: ____________ Frequency: __________

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Special instructions: ____

Call school nurse. Call parent/guardian if off school grounds.

IF INGESTION OR SUSPECTED INGESTION OF ALLERGEN OCCURS, SYMPTOMS ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Written by: ______________________________________ Date: ____________________

Parent/Guardian Signature to share this plan with Provider and School Staff: ____________________

Health Care Provider Signature:______________________________Date:______________________

Please Stamp

This plan is in effect for the current school year and summer school as needed. Revised 5/09