

**VISTA UNIFIED SCHOOL DISTRICT
EMERGENCY HEALTH CARE PLAN**

ALLERGIC REACTION TO: _____

Student: _____ **DOB:** _____ **Grade:** _____
Weight: _____ **Date Weighed:** _____ **School:** _____ **Teacher:** _____
Parent: _____ **Phone:** _____

FOR MILD ALLERGIC REACTION

<i>Symptoms</i>	<i>What to Do</i>
<ul style="list-style-type: none"> • Several hives • Itchy skin • Swelling at site, if an insect sting or bite • _____ • _____ 	<ul style="list-style-type: none"> • Student must be accompanied to health office. • Give _____ orally Antihistamine/Dose • Stay with student • Keep student quiet • Monitor symptoms • Contact parent

In some cases, symptoms may progress to a life threatening reaction.

FOR SEVERE ALLERGIC REACTION

<i>Symptoms</i>	<i>What to Do</i>
<ul style="list-style-type: none"> • Hives spreading over the body • Wheezing • Difficulty swallowing or breathing • Swelling of face or neck • Tingling/swelling of tongue • Vomiting • Shock <ul style="list-style-type: none"> • Pale/gray color • Clammy skin • Weak • Loss of consciousness 	<ul style="list-style-type: none"> • Administer EpiPen* <ul style="list-style-type: none"> <input type="checkbox"/> EpiPen (Physician, Please check appropriate one). <input type="checkbox"/> EpiPen Jr. • Call 911 immediately. (EpiPen only lasts 20 – 30 minutes. Always call paramedics!) • Contact parents or other emergency contact • Also give _____ orally Antihistamine/Dose/Time • Stay with student • Keep student quiet • Monitor Symptoms

- **Indicate here if student is capable of carrying/using own Epi-Pen.** Yes No
- **Location of EpiPen:** Locked med cabinet in Health Office Backpack
 Other _____

***Directions for use of EpiPen:**

1. Pull off grey cap
2. Place black tip against upper outer thigh
3. Press hard into outer thigh until it clicks
4. Hold in place for ten seconds, then remove
5. Discard EpiPen in impermeable container and dispose of per school policy or give to emergency responder. (Do Not Return to Holder).

<p><i>For School use only when medication(s) are used.</i></p> <input type="checkbox"/> _____ mg. given po @ ____ AM/PM <input type="checkbox"/> EpiPen given @ ____ AM/PM (Circle AM or PM) <input type="checkbox"/> EpiPen Jr. given @ ____ AM/PM (Circle AM or PM)	Signed _____ Date _____
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Physician's Signature: _____ **Date:** _____
Phone Number: _____ Fax Number: _____
Physician's License # _____
School Nurse: _____ **Date:** _____
Parent signature: _____ **Date:** _____