

# Emergency Care Plan

## FOOD ALLERGY



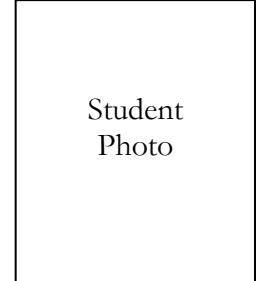
STUDENT: : \_\_\_\_\_ GRADE: \_\_\_\_\_

ALLERGIC TO: \_\_\_\_\_

DOB: \_\_\_\_\_ Teacher: \_\_\_\_\_ SCHOOL YEAR \_\_\_\_\_

Asthmatic:  Yes\*  No \*Increased risk for severe reaction

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### SYMPTOMS:

### GIVE MEDICATIONS Checked "X":

<b>MOUTH</b>	Itching & swelling of lips, tongue or mouth, mouth "feels hot"	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epi Pen
<b>THROAT*</b>	Itching, tightness in throat, hoarseness, cough	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epi Pen
<b>SKIN</b>	Hives, itchy rash, swelling of face and extremities	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epi Pen
<b>STOMACH</b>	Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epi Pen
<b>LUNG*</b>	Shortness of breath, repetitive cough, wheezing	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epi Pen
<b>HEART*</b>	Thready pulse, "passing out"	<input type="checkbox"/> Antihistamine <input type="checkbox"/> Epi Pen

**The severity of symptoms can change quickly.**

**\*All above symptoms can potentially progress to a life-threatening situation.**

**TREATMENT:** If ingestion is suspected and/or symptoms are as per the above:  
 Benadryl ordered:  Yes  No Give Benadryl \_\_\_\_mg PO per provider's orders.  
 Epinephrine ordered:  Yes  No Administer 0.15 mg 0.3 mg Epi Pen IM immediately.

Then call:

- Hatzalah 718-387-1750 or 718-230-1000 (inform them of type of emergency and ask for advanced life support)
- Mother: \_\_\_\_\_ Cell#: \_\_\_\_\_  
 Father: \_\_\_\_\_ Cell#: \_\_\_\_\_
- Dr. \_\_\_\_\_ at \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_