LIFE THREATENING EMERGENCY CARE PLAN

This section must be completed by a HEALTH CARE PROVIDER: (MD,DO,ND,DMD,DC,PA,ARNP or CNM)

Child's Name:	**Severe ALLERGY to:**
Date of Birth:	Other Allergies:

Date of Last Reaction:
Please list the specific symptoms the student has experienced in the past:

Location(s) where Epi-pen®/Rescue medications should be stored:			
☐ Med Box	☐ On Person	☐ Coach	☐ Other _____

EMERGENCY CARE PLAN

If you suspect a severe allergic reaction, immediately determine the symptoms, and treat the reaction as follows:

Symptoms (known symptoms 'X')

☐ MOUTH Itching, tingling, or swelling of the lips, tongue, or mouth
☐ SKIN Hives, itchy rash, and/or swelling about the face or extremities
☐ THROAT Sense of tightness in the throat, hoarseness, and hacking cough
☐ GUT Nausea, stomachache/abdominal cramps, vomiting and/or diarrhea
☐ LUNG Shortness of breath, repetitive coughing, and/or wheezing
☐ HEART "Thready" pulse, "passing out", fainting, blueness, pale
☐ GENERAL Panic, sudden fatigue, chills, fear of impending doom
☐ OTHER _____

Action to be taken: _____

_____

_____

_____

_____

* **Asthma?** ☐ Yes (High risk for severe reaction.) ☐ No
* If **only** lung symptoms are present without suspected ingestion first give:

☐ Fast acting inhaler _____
☐ Antihistamine
☐ Epi-pen®

*If only inhaler is given, and lung symptoms are not relieved within _____ minutes

☐ Repeat inhaler ☐ Antihistamine ☐ Epi-pen®

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MEDICATION DOSES

EpiPen ® (0.3) ☐ EpiPen Jr.® (0.15)☐	Side Effects:
Repeat dose of EpiPen®: ☐Yes ☐ No	If YES, when
Antihistamine _____cc/mg	Give: _____Teaspoons _____Tablets by mouth

¤ GIVE MEDICATION AS ORDERED ABOVE & AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.
« NOTE TIME_____AM/PM (Epi-pen®/adrenaline given)
« NOTE TIME_____AM/PM (Antihistamine given)
¤ CALL 911 IMMEDIATELY. 911 must be called WHENEVER Epi-pen® is administered.
¤DO NOT HESITATE to administer Epi-Pen® and to call 911 even if the parents cannot be reached.
¤Advise 911 that the student is having a severe allergic reaction and Epi-Pen® is being administered.
¤ An adult trained in CPR is to stay with student –monitor and begin CPR as necessary.
« Student should remain with a staff member trained in CPR at the location where symptoms began until EMS arrives.
« Notify the front desk and parent/guardian
« Dispose of used Epi-Pen® in "sharps" container or give to EMS along with a copy of the Emergency Care Plan

« An Adult must administer the Epi-Pen to the child. ☐ Yes ☐ No
« The child may self-administer the Epi-Pen. ☐ Yes ☐ No
« It is medically necessary for this student to carry an Epi-Pen with them at all times. ☐ Yes ☐ No
« The child has demonstrated the ability to use the Epi-Pen on their own to the LHP. ☐ Yes ☐ No

	Start Date:	End Date:
Licensed Health Professional's Signature	Today's Date:	
Licensed Health Professional's Printed Name	Phone Number:	

For STC Staff Use Only:

Student has demonstrated to the STC staff, the skill necessary to use the medication and any device necessary to self-administer the medication.
Device(s) if any, used _____ Expiration date(s): _____

_____
STC Staff Signature Date:

A copy of the Emergency Care Plan will be kept in Jackrabbit and will be accessible to all staff members who are involved with the student.

LIFE THREATENING EMERGENCY CARE PLAN

This section must be completed by a LEGAL PARENT/GUARDIAN:

Emergency Medication(s) to be administered: _____

Please check only one box:

□ In the case of an emergency I request that authorized persons at STC administer the above listed medication.

□ I request that my child be allowed to **self-carry and/or self-administer this medication.** My student and I understand the responsibility of self-carrying medication at STC and recognize that the STC staff will not track compliance, expiration, or amount. I agree to hold harmless and indemnify STC and STC's officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by my student.

□ I am 18 years old and signing this form on my own behalf. I agree to hold harmless and indemnify STC and STC's officers, employees, and agents against all claims, judgments, or liabilities arising out of my self-administration and carrying of medication.

- I request this medication to be given as ordered by the licensed health professional (i.e.: doctor)
- I understand that the medication(s) will be given in the case of a medical emergency by trained and supervised STC staff.
- I release STC and STC's officers, employees, and agents from any liability in the administration of this medication at any STC facility.

_____
Student First and Last Name

_____ Today's Date: _____
Parent / Guardian Signature

_____ Phone: _____
Parent / Guardian First and Last Name

_____
Relationship to Student