ANAPHYLAXIS - EMERGENCY HEALTH CARE PLAN 2019

(Complete and return only if your camper has a diagnosed allergic condition.)

Camper Name: _____ Date of Birth: ____-____-_____ Weight: ____lbs

ALLERGY TO: _____

Asthmatic: No ____ Yes ____ *High risk for severe reaction

☐ Student may self-carry epinephrine

☐ Student may self-administer epinephrine

SIGNS OF AN ALLERGIC REACTION INCLUDE:

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, abdominal cramps, vomiting, and/or diarrhea
LUNG*	shortness of breath, repetitive coughing, and/or wheezing
HEART*	“thready” pulse, “passing-out”

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

ACTION FOR MINOR REACTION:

If ingestion is suspected and symptoms include _____

give _____

NOTIFY PARENT(S) AND OBSERVE STUDENT IN THE HEALTH OFFICE FOR 30 MINUTES FOR SIGNS OF PROGRESSION OF SYMPTOMS. IF CONDITION DOES NOT IMPROVE IN 10 MINUTES, FOLLOW STEPS FOR MAJOR REACTION BELOW.

ACTION FOR MAJOR REACTION:

1. If ingestion is suspected and symptoms include _____

give _____ IMMEDIATELY!

and _____ IMMEDIATELY!

2. **CALL 911 RESCUE SQUAD IMMEDIATELY AFTER THE EPIPEN IS ADMINISTERED.**

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised.

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS CANNOT BE REACHED!

EMERGENCY CONTACTS:

Parent/Guardian #1: _____ Best Phone: _____

Parent/Guardian #2: _____ Best Phone: _____

Additional Contact: _____ Best Phone: _____

Additional Contact: _____ Best Phone: _____

Physician Signature: _____ Date: _____

Physician Name (Please Print) : _____

Physician Phone Number: _____

I hereby authorize Baker Demonstration School to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize Baker Demonstration School staff members to disclose my child's protected health information to the student's teachers and any other appropriate school personnel (including those involved with the student during after-school activities) to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian Signature: _____ Date: _____

(For Office Use Only) TRAINED STAFF MEMBERS:

1. _____ *Room:* _____

2. _____ *Room:* _____

3. _____ Room: _____