Canton Public Schools
Emergency Health Care Plan
School Year: September _____ to August _____

****
* **Attach student's** *
* **photo here** *
****

STUDENT'S NAME: _____
DATE OF BIRTH: _____ **GRADE:** _____ **HOME ROOM/TEACHER:** _____
ALLERGY TO:_____

Asthmatic
□ Yes* □ No
*Higher risk for severe reaction

Allergy Aware Table in Cafeteria
□ Yes □ No

STEP 1: TREATMENT ♦

To be determined by physician authorizing treatment

Symptoms:	**Give Checked Medication * ***
▪ If a food allergen has been ingested, but *no symptoms*:	□ EpiPen □ Antihistamine
▪ Mouth = itching, tingling, or swelling of lips, tongue, mouth	□ EpiPen □ Antihistamine
▪ Skin = Hives, itchy rash, swelling of the face or extremities	□ EpiPen □ Antihistamine
▪ Gut = Nausea, abdominal cramps, vomiting, diarrhea	□ EpiPen □ Antihistamine
▪ Throat = Tightening of throat, hoarseness, hacking cough	□ EpiPen □ Antihistamine
▪ Lung = Shortness of breath, repetitive coughing, wheezing	□ EpiPen □ Antihistamine
▪ Heart = Thready pulse, low blood pressure, fainting, pale, blueness	□ EpiPen □ Antihistamine
▪ Other = _____	□ EpiPen □ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give	□ EpiPen □ Antihistamine

The severity of symptoms can quickly change. = Potentially life-threatening.

DOSAGE
Epinephrine: give _____inject intramuscularly)
Medication/dose/route

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

Physician Signature _____Date:_____

I have evaluated the health status and abilities of this student and deem that they may carry their Epinephrine and self administer if needed YES □ NO □

Physician Signature _____**Date**: _____

♦ STEP 2: EMERGENCY CALLS

1. Call 911 State that an allergic reaction has been treated,
2. Dr. _____ at _____
3. Emergency contacts:

Name/Relationship Phone Number(s)

a. _____ 1.)_____ 2.) _____
b. _____ 1.)_____ 2.) _____
c. _____ 1.)_____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

TRAINED STAFF MEMBERS

1._____ROOM_____

2. _____ ROOM _____

3._____ROOM_____

IMPORTANT INFORMATION

The student's self administration is monitored based on their abilities and health status. Monitoring may include teaching the student the correct way of taking the medication, visual observation to ensure compliance, recording that the medication was taken, and notifying the parent, guardian or licensed prescriber of any side effects, variation from the plan, or the student's refusal or failure to take the medication;

Permission to self administer medication may be rescinded at the school nurse's discretion for noncompliance of above requirements.

PARENT /GUARDIAN AUTHORIZATIONS

I authorize permission for the school nurse or trained staff member to administer Epinephrine to my child in the event my child is unable to self administer, in school or on a field trip. I agree to the care plan and allow the nurse to share information with appropriate staff as deemed necessary for my child's health and safety.

_____ _____

Parent/Guardian Signature Date

I authorize permission for my child to self carry and self medicate with Epinephrine as noted in the agreement above.

_____ _____

Parent/Guardian Signature Date

NURSING

I have evaluated the health status and abilities of this student and deem that they may carry their Epinephrine for self administration if needed

_____ _____

School Nurse Signature Date