

**Attach Student's
Picture**

**Grand Prairie Independent School District
Health Services**

EMERGENCY CARE PLAN

School: _____ Phone: _____ Date: _____

Student's Name: _____ Physician's Name: _____

Teacher/Grade: _____ Phone Number: _____

Birthday: _____ Hospital: _____

ALLERGIC TO: _____

Asthmatic: _____ ("yes" may indicate higher risk for severe reaction)

Emergency Contacts:

Mother: _____ Father: _____

Home Phone: _____ Home Phone: _____

Work/Other Phone: _____ Work/Other Phone: _____

Pager/Cell Phone: _____ Pager/Cell Phone: _____

Other Contact (Name/Day Phone): _____

MEDICATION (all medication is kept locked in the nurse's clinic or main office)

Check medication available (medication permit(s) attached):

EpiPen: _____ Expiration Date: _____

EpiPen Jr.: _____ Expiration Date: _____

Other: _____

TRAINED STAFF MEMBERS: (Name, job description, date trained)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

SIGNS OF AN ALLERGIC REACTION: *attached*

PAST ALLERGIC REACTIONS:

1. Number of incidents: _____

2. Symptoms that occurred: _____

3. How allergic reaction(s) treated: _____
(Has EpiPen been used previously, oral medications, hospitalization?)

TREATMENT FOR SEVERE ALLERGIC REACTION:

1. Administer student's prescribed epinephrine (EpiPen) injection (see medication permit to determine what symptoms constitute a severe reaction)
2. Call 911; inform emergency personnel of a severe allergic reaction and that epinephrine injection has been given
3. Monitor airway and breathing; keep student calm/warm
4. Call parent(s)
5. Call student's physician to inform of emergency situation
6. Record symptoms observed, administration of medication, source of exposure, response to medication, EMS action

FOOD SERVICES NOTIFICATION (FOOD ALLERGY):

1. Cafeteria manager notified (student's name, grade, teacher, food allergy):
Manager's name: _____
Date notified: _____
2. Student will eat only snacks brought from home: Yes _____ No _____

NOTIFICATION OF PARENTS (FOOD ALLERGY)

1. Letter sent home to parents advising not to send snacks/classroom treats with specified food allergen:
Homeroom: _____ Grade Level: _____
2. Student will eat only snacks brought from home: Yes _____ No _____

STAFF WHO WILL HAVE ACCESS TO THE EMERGENCY CARE PLAN (NAME AND JOB DESCRIPTION):

- | | |
|----------|--|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. <u>Homeroom substitute teacher</u> |

If student has been exposed to a specified allergen and exhibits only a mild allergic reaction while at school, the parent will be asked to take the child home for observation.

I have reviewed the Emergency Care Plan as written and have made any changes needed.

Parent signature: _____ Date reviewed: _____