**Seguin** SCHOOL HEALTH SERVICES
exceptional students to exceptional citizens
INDEPENDENT SCHOOL DISTRICT

# EMERGENCY HEALTH CARE PLAN

## Allergic Emergency / Epi-Pen Orders

Student:________________________________________ Grade:_____ DOB:________________ ID#: _______________

Allergens requiring Epi-Pen:______________________________ Asthmatic: ❒ Yes ❒ No (increased risk for severe reactions)

Mother:_________________________Home #:________________ Work #______________ Cell #: _______________

Father:_________________________ Home #:________________ Work #_______________ Cell #: _______________

Emergency Contact:________________________________ Relationship:_____________ Phone:___________________

**SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THE FOLLOWING:**
**Please circle student's reaction(s):**

- MOUTH Itching and swelling of lips, tongue or mouth, mouth "feels hot"
- THROAT Itching, tightness in throat, hoarseness, cough
- SKIN Hives, itchy rash, swelling of face and extremities
- STOMACH Nausea, abdominal cramps, vomiting, diarrhea
- LUNG Shortness of breath, repetitive cough, wheezing
- HEART "Thready pulse," "passing out"

Other (please describe):_______________
________________________________
________________________________
________________________________
________________________________

**TREATMENT:** **THE SEVERITY OF SYMPTOMS CAN CHANGE QUICKLY – IT IS IMPORTANT THAT TREATMENT BE GIVEN IMMEDIATELY.**

Treatment should be initiated: ❒ with symptoms ❒ without waiting for symptoms

Benadryl ordered: ❒ Yes ❒ No ❒ Special Instructions: ________________________________________________

Benadryl given first? ❒ Yes ❒ No Give ______________ (dose) Benadryl per provider's orders.

Epinephrine ordered (Epi-Pen): ❒ Yes ❒ No ❒ Special Instructions: ________________________________________

Student has Self Carry Orders on file: ❒ Yes ❒ No

Call School Nurse @___________________________ Notify Parent/Guardian.

**IF EPI-PEN IS ADMINISTERED STAFF ARE REQUIRED TO CALL 911**

Transportation Plan: ❒ Medication available on bus ❒Medication is NOT available on bus ❒ Does not ride bus

❒ Special instructions:______________________________________________________________________________

Healthcare Provider:_______________________________________________ Phone: __________________________

Written by:________________________________________________________ Date:____________________________

❒ Copy provided to Parent ❒ Copy sent to the Healthcare Provider

Parent/Guardian Signature:_____________________________________________________ Date:_________________

Doctor's/Health Care Provider Signature:________________________________________________ Date: ______

*This plan is in effect for the current school year and summer school as needed.*

*Revised 06-07-21*