SEVERE ALLERGY EMERGENCY CARE PLAN 2016-2017 SCHOOL YEAR
GREENFIELD-CENTRAL COMMUNITY SCHOOL CORPORATION

A **severe** allergy is one that requires emergency medical treatment. If your student requires emergency treatment, including the use of diphenhydramine (Benadryl) or an EpiPen, this form must be completed and signed by you and a physician each school year.

Student's Name: _____ Date of Birth: _____

Student's Address: _____

EMERGENCY CONTACTS

Name	Relationship	Telephone	Email
1.			
2.			
3.			

TO BE COMPLETED BY THE PHYSICIAN

This student has the following allergies that require the use of emergency medication:

_____

Is this student asthmatic? □ Yes (an emergency care plan for asthma must also be completed) □ No

STEPS TO TAKE IF STUDENT HAS INGESTED, BEEN STUNG, OR BEEN EXPOSED TO ALLERGEN:

1. Give the following medications (Form 5330F1 and/or Form 5330F1b must also be completed):

Name of Medication	Dose	Symptoms
Name of Medication	Dose	Symptoms

2. Call 911 immediately if epinephrine is administered.
3. Notify parent/guardian and corporation nurse.
4. Other instructions/comments: _____

_____

This student □ Should □ Should Not carry their own epinephrine auto-injector. They have been instructed by me, the physician, on how and when to administer this medication. I advise that in addition to carrying their injector, one also be stored in the clinic for use in an emergency situation.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Telephone Number: _____

(-OVER-)

TO BE COMPLETED BY THE PARENT/GUARDIAN

In addition to the above instructions from the physician, I wish to communicate the following information to school personnel regarding my student:

_____

_____

_____

As the parent/guardian of a student with a severe allergy, I understand it is **my** responsibility to inform bus drivers, coaches, extra-curricular sponsors, tutors, etc., of my student's condition.

If the physician has indicated that my student can carry emergency medication, I authorize my student to do so. My student has been instructed on the purpose of and appropriate method and frequency of use of the prescribed medication. He/she also understands the importance of reporting immediately to the school health assistant at the first sign of an allergic reaction. I understand that 911 will be activated if epinephrine is used by my student or school personnel. I understand that it is **strongly advised** that an extra auto-injector be stored in the clinic even if my student is authorized to carry their auto-injector.

I hereby give permission for the exchange of medical information between the corporation nurse, health assistant, school principal, and the physician listed above. I also give permission for clinic personnel to share this medical information with school staff as needed to help protect my student's safety and well-being.

I agree to and wish to implement this emergency care plan for my student.

Parent/Guardian's Signature: _____ Date: _____

Printed Name: _____

TO BE COMPLETED BY SCHOOL PERSONNEL

Date ECP received by clinic personnel: _____

□ ECP Reviewed by Health Assistant _____

□ ECP Reviewed by Corporation Nurse _____