

**SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS
EMERGENCY CARE PLAN: LATEX ALLERGY**

To be completed by Parent

Student _____ Grade _____ Teacher/HR _____ DOB _____

Asthmatic: ___yes* ___no *increased risk for severe reaction Insurance: _____

Mother's Name: _____ Home# _____ Work# _____ Cell _____

Father's Name _____ Home# _____ Work# _____ Cell _____

Emergency Contact: _____ Relationship _____ Phone _____

I give permission to share this plan with physician and school staff. I agree with the Health Care Provider's orders as outlined below:

Parent signature _____ Date _____

SYMPTOMS AND SIGNS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

(highlighted indicates previous response by the student)

- **MOUTH** itching & swelling of 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, and/or vomiting
- **LUNG** shortness of breath, repetitive coughing and/or wheezing
- **HEART** "THREADY" PULSE, "PASSING-OUT"



The severity of the symptoms can change quickly. It is important that treatment is given immediately.

To be completed by Health Care Provider

Allergens: (Please list) _____

ACTION:

If **contact is suspected and/or the only symptom(s)** are: _____

Give _____ **IMMEDIATELY.**
Medication(s)/dose/route

If **the following symptom(s)** develop: _____

Give _____ **IMMEDIATELY.**
Medication(s)/dose/route

I give permission for this student to **self-carry** and **self-administer** the above medication(s). ___Yes ___No
If so, she/he has been instructed in and understands the purpose and appropriate method and frequency of administration of the above medication(s).

Health Care Provider _____ **Phone** _____ **FAX** _____
Printed name

Health Care Provider Signature _____ **Date** _____

Information for Staff:

If symptoms or suspected contact occur, follow plan, then contact school nurse at _____ and parent immediately.
If **Epi-Pen/Epi-Pen Jr., Twinject 0.3mg / Twinject 0.15mg** is administered, **call 911**. It provides a 20 minute response window.
The student may experience an increased heart rate. This is normal. A staff member should accompany student to ER if the parent/emergency contact cannot be reached.

This plan is in effect for the current school year.

Please return to _____ Phone # _____ FAX _____

IF EPI-PEN IS ADMINISTERED COMPLETE BACK OF FORM AND SEND TO ER WITH STUDENT.

**SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS
EMERGENCY CARE PLAN: LATEX ALLERGY**

STUDENT NAME _____

Circumstances leading to administration of Epi-Pen _____

CIRCLE ONE : **Epi-Pen / Epi-Pen Jr. Twinject 0.3mg / Twinject 0.15mg given.**

DATE: _____ **TIME** _____

RIGHT

LEFT

LOCATION: Place an X on area where Epi_Pen / Twinject was administered.

SIGNATURE OF STAFF MEMBER WHO ADMINISTERED EPI-PEN

SEND THIS FORM TO ER WITH STUDENT