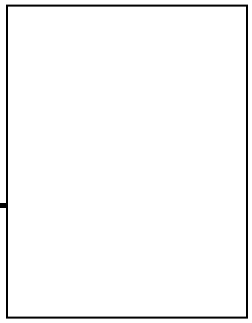
CORNWALL CONSOLIDATED SCHOOL
EMERGENCY HEALTH CARE PLAN



ALLERGY TO: _____

ASTHMA ☐ Yes ☐ No

Student's
Name_____DOB_____Teacher_____

Parent/Guardian: _____ Telephone:_____

Emergency Contacts_____ _____
Relationship Phone

_____ _____
Relationship Phone

IF STUDENT HAS INGESTED OR THINKS HE/SHE HAS INGESTED THE ABOVE NAMED FOOD:
ACTION:

_____ Observe student for symptom's of anaphylaxis**

_____ Administer **adrenaline** before symptoms occur **EpiPen Jr. Sr.**

_____ Administer **adrenaline** if symptoms occur **EpiPen Jr. Sr.**

_____ Administer **Benadryl** _____Tsp./ Mg.

_____ Administer _____

_____ Call Rescue Squad for transport to ER for further evaluation X 4 Hours

_____ Call: Mother _____Father _____or emergency contacts

_____ Call Dr._____ At _____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL RESCUE SQUAD EVEN IF PARENTS OR DR. CANNOT BE REACHED!

_____ **M.D.** _____
Doctor's Signature Date

** **SYMPTOMS OF ANAPHYLAXIS**
Chest tightness, cough, shortness of breath, wheezing
Tightness in throat, difficulty swallowing, hoarseness
Swelling of lips, tongue, throat
Itchy mouth, itchy skin, hives, rash
Stomach cramps, vomiting, diarrhea
Dizziness or faintness

I HAVE REVIEWED AND UNDERSTAND THE ABOVE INFORMATION. **I consent for the exchange of information between the school nurse and the prescriber regarding this plan**

_____
Parent/Guardian Signature