

Life-Threatening Food Allergy Emergency Care Plan (ECP)

Student Information			
Senior Name:	Life-Threatening ALLERGY to:		
Emergency Contact 1 (Full Name & Phone #):	Emergency Contact 2 (Full Name & Phone #):		
Senior should avoid contact with this/ these allergen(s):			
Other allergies:			
Will the senior be bringing separate food to the event? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Will the senior be carrying an EpiPen on his or her person during the event? <input type="checkbox"/> YES <input type="checkbox"/> NO			
School:	Birthdate:	Night-of-Event Bus #: <i>Onsite help to enter day of event</i>	
Routine medications (at home/school):	Asthmatic? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of last reaction:	
Is it medically necessary for student to carry their own EpiPen? <input type="checkbox"/> YES <input type="checkbox"/> NO	High Risk for life-threatening reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Please list the specific symptoms the student has experienced in the past.			
<input type="checkbox"/> MOUTH Itching, tingling, and/or swelling of the lips, tongue, or mouth <input type="checkbox"/> SKIN Hives, itchy rash, and/or swelling about the face or extremities <input type="checkbox"/> THROAT Sense of tightness in the throat, hoarsened and hacking cough <input type="checkbox"/> GUT Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea <input type="checkbox"/> LUNG Shortness of breath, repetitive coughing, and/or wheezing <input type="checkbox"/> HEART “Thready” pulse, “passing out”, fainting, blueness, and pale <input type="checkbox"/> GENERAL Panic, sudden fatigue, chills, fear of impending doom <input type="checkbox"/> OTHER _____			
IF YOU SUSPECT A LIFE-THREATENING ALLERGIC REACTION TO FOOD, IMMEDIATELY ADMINISTER EPINEPHRINE AND CALL 911.			

Student's Standard Medication Doses		
EPIPEN (.03) <input type="checkbox"/> Student May Administer: <input type="checkbox"/> YES <input type="checkbox"/> NO	EPIPEN JR. (0.15) <input type="checkbox"/> Student May Administer: <input type="checkbox"/> YES <input type="checkbox"/> NO	ANTI-HISTAMINE: _____ CC / MG (circle one)
Repeat dose of EPIPEN: <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, when:		EpiPen Side Effects:
Give (list medication) _____ _____ Teaspoons _____ Tablets by mouth		Other Medication Side Effects:
I agree to notify the Planning Committee of any changes to the above information between now and the date of graduation.		By: _____ (Parent/Guardian's Signature) Date: _____

Action Plan if an Allergic Reaction Occurs During the Event
<ol style="list-style-type: none"> 1. Administer Epinephrine AND CALL 911 (DO NOT HESITATE to administer Epinephrine). 2. 911 MUST BE CALLED IF EPINEPHRINE IS ADMINISTERED. 3. Advise 911 that the student is having a life-threatening allergic reaction AND Epinephrine is being administered. REQUEST ADVANCED LIFE SUPPORT. 4. Note the time of Epinephrine administration: _____ AM / PM 5. Place EpiPen in the container provided AND send with emergency responders along with ECP. 6. Call Parents or other emergency contacts.
Signature of Emergency Responders: _____ Date: _____
Printed Name of Emergency Responders: _____