

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	
<u>Please list the specific symptoms the student has experienced in the past.</u> <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) <div style="text-align: right;">Date: _____</div>	
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: _____			