

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): Is it medically necessary for student to carry their own EpiPen? <input type="checkbox"/> YES <input type="checkbox"/> NO		Asthmatic? <input type="checkbox"/> YES <input type="checkbox"/> NO High Risk for life-threatening reaction? <input type="checkbox"/> YES <input type="checkbox"/> NO
Date of last reaction:		

Please list the specific symptoms the student has experienced in the past.

- MOUTH Itching, tingling, and/or swelling of the lips, tongue, or mouth
- SKIN Hives, itchy rash, and/or swelling about the face or extremities
- THROAT Sense of tightness in the throat, hoarsened and hacking cough
- GUT Nausea, stomach ache/abdominal cramps, vomiting and/or diarrhea
- LUNG Shortness of breath, repetitive coughing, and/or wheezing
- HEART “Thready” pulse, “passing out”, fainting, blueness, and pale
- GENERAL Panic, sudden fatigue, chills, fear of impending doom
- 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	ANTIHISTAMINE: _____ CC / MG (circle one)
Repeat dose of EPIPEN: <input type="checkbox"/> YES <input type="checkbox"/> NO	EpiPen Side Effects:	
If YES, when: 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

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: _____