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EAST ISLIP
UNION FREE
SCHOOL DISTRICT

East Islip School Dist.
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Emergency Health Care Plan
FOOD ALLERGY

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Asthmatic: ❑ Yes ❑ No (increased risk for severe reaction) Allergen(s): _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____
Phone: _____

Student Photo

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

- **MOUTH** Itching & swelling of lips, tongue or mouth, mouth "feels hot"
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- **LUNG** Shortness of breath, repetitive, cough, wheezing
- **HEART** "Thready pulse," "passing out"

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

STAFF MEMBERS INSTRUCTED ON SYMPTOMS: ❑ Classroom Teacher(s) ❑ Special Area Teacher(s) ❑ Administration ❑ Support Staff

TREATMENT: Rinse contact area with water if appropriate

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms
Benadryl ordered: ❑ Yes ❑ No Give _____ Benadryl per provider's orders

Call school nurse. Call parent/guardian if off school grounds.
Epinephrine ordered: ❑ Yes ❑ No Special instructions: _____

IF INGESTION OR SUSPECTED INGESTION OF ALLERGEN OCCURS, SYMPTOMS ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIDATELY AND CALL 911.

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Licensed Healthcare Provider Signature: _____ Phone: _____
Written by: _____ Date: _____

I give permission to allow communication between physician and East Islip School District staff – this plan can be shared with provider & school staff as applicable.

Parent/Guardian Signature: _____

This plan is in effect for the current school year and summer school as needed.