



EMERGENCY CARE PLAN

Eden Central School District

3150 Schoolview Road
Eden, New York 14057



Mr. Jeffrey A. Sortisio
Superintendent
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Mrs. Merrie Maxon
Director of Pupil Personnel Services
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LATEX ALLERGY

Student: _____ Grade: _____ DOB: _____

Asthmatic: Yes No (increased risk for severe reaction) Severity of reaction(s): _____

School Contact: _____ Documentation: ON FILE ATTACHED

Mother: _____ Home #: _____ Work #: _____ Cell #: _____

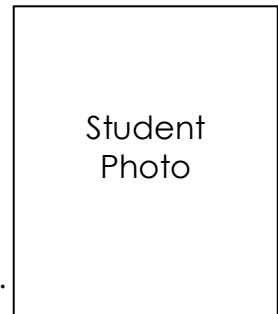
Father: _____ Home #: _____ Work #: _____ Cell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

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

- **MOUTH** Itching & swelling of lips, tongue or mouth
- **THROAT** Itching, tightness in throat, tightness in chest
- **SKIN** Hives, warmth, itchy rash, generalized swelling
- **STOMACH** Nausea, abdominal cramps, vomiting and/or 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:

- Administration Classroom Teacher(s) Special Area Teacher(s)
 Support Staff Transportation Staff

TREATMENT: Rinse contact area with water.

Benadryl ordered: Yes No Give _____ Benadryl per provider's orders

Call school nurse at _____. Call parent/guardian if off school grounds.

Epinephrine ordered: Yes No Special instructions: _____

IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING ARE SEEN AT THE SITE AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Preferred Hospital if transported: _____

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.

Transportation Plan: Medication available on bus Medication NOT available on bus Does not ride bus

Special instructions: _____

Written by: _____

Date: _____

Copy provided to Parent

Parent/Guardian Signature to share this plan with Provider and School Staff: _____