



**RYE CITY SCHOOL DISTRICT  
HEALTH CARE SERVICES  
Rye, NY 10580**

Place  
Child's  
Picture  
Here

**ALLERGY  
EMERGENCY HEALTH CARE PLAN:**

Name of Student: \_\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Asthma (high risk for severe reaction): **Yes**  **No**  Inhaler Order \_\_\_\_\_  
Medications/Dose/Route

**STEP 1: TREATMENT (To be determined by physician)**

**SYMPTOMS:**

- Mouth - Itching, tingling, or swelling of lips, tongue, mouth
- Skin - Hives, itchy rash, swelling of the face or extremities
- Gut - Nausea, abdominal cramps, vomiting, diarrhea
- Throat - Tightening of throat, hoarseness, hacking, cough
- Lung - Shortness of breath, repetitive coughing, wheezing
- Heart - Thready pulse, low blood pressure, fainting, pale, blueness
- Other - \_\_\_\_\_
- If reaction is progressing (several of the above areas affected) give

**DOSAGE:**

Epinephrine Auto-Injector (circle the dose): **0.3mg IM** or **0.15mg (Jr.) IM**

Antihistamine Order: \_\_\_\_\_  
Medications/Dose/Route

Authorization for Self-Directed (For EPI-Pen & Inhaler Only): **Yes/No (circle one)**

He/she is self-directed, has been instructed in the procedure of self-administration and can assume responsibility for carrying his/her own properly labeled medication in the original container. He/she understands the purpose, the correct dose, the possible side effects, and the frequency of use. I request that he/she be permitted to carry his/her own medication, including Field Trips, or to keep own medication in his/her locker. School Nurse has final approval.

Doctor's Signature: \_\_\_\_\_ Date \_\_\_\_\_  
(Required)

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**STEP 2: EMERGENCY ACTION**

1. Give medication as prescribed under Step 1: Treatment.
2. CALL AMBULANCE: 911 (Police: (914) 967-1234). Inform that an allergic reaction is occurring. Bring epinephrine.
3. CALL: Parent/Guardian \_\_\_\_\_

I request that my child receive the medication as prescribed above by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I give permission for my child to receive the prescribed medication as directed and under the supervision of the school nurse or designated other.

I release the Nurse to inform all those (Principal/Faculty/Staff directly involved with the student) on a "need-to-know" basis all pertinent health information for his/her safety during the school year.

Exceptions: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_