San Ramon Valley Unified School District
699 Old Orchard Drive/Danville, CA 94526

MEDICATION AND EMERGENCY HEALTH CARE PLAN FOR LIFE-THREATENING ALLERGIES

Place Student Picture Here

ALLERGY TO: _____

STUDENT'S NAME: _____Grade____ BIRTH DATE _____

Asthmatic circle **yes*** **no** *High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:	Symptoms:
• **MOUTH**	itching & swelling of the lips, tongue, or mouth
• **THROAT***	itching and/or a sense of tightness in the throat, hoarseness, & hacking cough
• **SKIN**	hives, itchy rash, and/or swelling about the face or extremities
• **GUT**	nausea, abdominal cramps, vomiting, and/or diarrhea
• **LUNG***	shortness of breath, repetitive coughing, and/or wheezing
• **HEART***	"thready" (weak) pulse, "passing-out"

The severity of symptoms can quickly change.

***All above symptoms can potentially progress to a life-threatening situation!**

ACTION IF INGESTION/EXPOSURE IS SUSPECTED:

1. **GIVE** _____
   medication/dose/route
2. **GIVE** _____
   medication/dose/route

Student may carry Epi-Pen on his/her person while at school **MD initial: YES____ NO____**

Student is trained in Epi-Pen administration **MD initial: YES____ NO____**

Student may self medicate when possible* **(with School Nurse or Administrator approval)** **MD initial: YES____ NO____**

3. **CALL 911 (notify EMS of any medication given)**
4. **CALL Parent _____or emergency contacts**
   Name and phone number(s) (see attached)
5. **Other MD instructions**_____

_____

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS CANNOT BE REACHED

AUTHORIZING MD SIGNATURE:_____DATE:_____

MD NAME & ADDRESS STAMP:

Student:
I agree with the above allergy plan. Signature: _____DATE:_____
Parent:
I agree with the above allergy plan. Signature: _____DATE:_____