

# Life-Threatening Food Allergy Emergency Care Plan (ECP)

## Student Information

<b>Senior Name:</b>	<b>Life-Threatening ALLERGY to:</b>
<b>Emergency Contact 1 (Full Name &amp; Phone #):</b>	<b>Emergency Contact 2 (Full Name &amp; Phone #):</b>

Senior should avoid contact with this/ these allergen(s):

Other allergies:

Will the senior be bringing separate food to the event? ☐ YES ☐ NO  
 Will the senior be carrying an EpiPen on his or her person during the event? ☐ YES ☐ NO

School:	Birthdate:	Night-of-Event Bus #: <i>Onsite help to enter day of event</i>
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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:
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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)
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Repeat dose of EPIPEN: ☐ YES ☐ NO

If YES, when:

Give (list medication) \_\_\_\_\_  
 \_\_\_\_\_ Teaspoons \_\_\_\_\_ Tablets by mouth

EpiPen Side Effects:

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:** \_\_\_\_\_