



SYRACUSE CITY SCHOOL DISTRICT
EMERGENCY CARE PLAN
FOOD ALLERGY

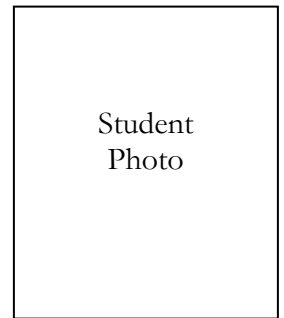


Student: _____ Grade: _____ School Contact: _____ DOB: _____
Asthmatic: [] Yes [] No (increased risk for severe reaction) Allergen(s): _____
Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____
Father: _____ FHome #: _____ FWork #: _____ FCell #: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

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

- MOUTH Itching & swelling of lips, tongue or 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 give immediately.



STAFF MEMBERS INSTRUCTED: [] Classroom Teacher(s) [] Special Area Teacher(s)
[] Administration [] Support Staff [] Transportation 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 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: _____

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

[] Copy provided to Parent [] Copy sent to Healthcare Provider

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