EMERGENCY CARE PLAN FOR SEVERE ALLERGY
West Fargo Public Schools

Student Name_____ **DOB** _____ **Grade**_____ **Bus Student: YES OR NO**

Student is allergic to_____ **Parent/Guardian**_____

Work Phone_____ **Cell Phone**_____ **Home Phone**_____

Additional Emergency Contact_____ **Phone**_____

Preferred Hospital_____ **Physician Signature**_____

TO BE COMPLETED BY THE PHYSICIAN:

Reaction caused by: Please circle all that apply. Inhalation Ingestion Contact

Class of allergy: Please circle 1- Low 2-Moderate 3- High 4-Very high 5- **Very** high 6- Highest class

Symptoms this allergy has caused: Please circle all that apply.

Mouth: itching and/or swelling of lips, tongue or mouth **Gut:** nausea, vomiting, diarrhea

Throat: sense of tightness in the throat, difficulty swallowing, hoarseness, cough

Heart: weak pulse, fainting, or dizziness **Lungs:** shortness of breath, wheezing, difficulty breathing

Skin: hives, itchy rash, flushing of face, swelling on face or extremities **Other:**_____

I give permission to the principal and to the school nurse to share this "Emergency Care Plan" with school faculty and staff as appropriate. This information will be shared for the purpose of providing first aid or other specific emergency care as described in the plan. I approve of the above "Emergency Care Plan" and request school personnel to follow the above "Emergency Care Plan" in the event of an emergency involving my child. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this "Emergency Care Plan." I further agree that the school personnel or nurse may contact the prescriber as needed and that medical information may be shared with school personnel who need to know.
In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the rendering of care in accord with the above "Emergency Care Plan" from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of care in accord with the above "Emergency Care Plan".

Medication provided by parent/guardian to treat allergic reaction

These medications **require** a written physician's prescription for the school to give. Parent is responsible for keeping track of expiration dates on medication and replacing medication before the expiration date.

***Epinephrine (Epi Pen)**Yes/No (circle one) ***Antihistamine** (i.e. Benadryl) Yes/No (circle one)
*Medication **IS** required at school (circle one) Yes/No Medication authorization on file Yes/No

Where will the Epi Pen/Antihistamine be kept (circle all that apply)
On student (pocket, binder, purse, backpack) Classroom Nurses office Locker Gym Locker

West Fargo Schools will require a doctor's written statement for food allergies that require omission or substitutions of specific foods.

_____ _____
Parent/Guardian Signature Date