

POPE JOHN PAUL II HIGH SCHOOL

181 Rittenhouse Road
Royersford, PA 19468

Telephone 484-975-6500 X3061
Fax: 610-792-3169

Emergency Care Plan LATEX ALLERGY

Student: _____ Grade: _____ School Contact: _____ DOB: _____
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
- . THROAT Itching, rightness 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.**

Student
Photo

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

TREATMENT: Rinse contact area with water.

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 ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE 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: _____