

LEXINGTON PUBLIC SCHOOLS
Lexington, Massachusetts
EMERGENCY HEALTH CARE PLAN
School Year September August 2009- June 2010

PHOTO MAY BE PLACED
HERE

Dear Parent/Guardian:

Your child has been noted to have a significant food, latex, or stinging insect allergy that could require emergency treatment while in school. In order to insure the best possible treatment plan, I would like you to have your child's physician, preferably the Allergist, formulate an **Emergency Health Care Plan** that I can follow. The usual **Medication Administration Form** must be filled out by the physician to enable us to administer an EpiPen, Benadryl, or other designated medication for an allergic reaction, and should be returned with this plan.

Student's name: _____ **Grade:** _____

School: _____ **Room/Team** _____

Student's parents'/guardians' names:

_____ Home # _____ Wk# _____
_____ Home # _____ Wk# _____

Other contacts: cell# _____ beeper# _____

To be completed by Physician

MD's name: _____ Phone # _____
(please print)

Please check: Allergist _____ Primary Care Physician _____

My patient, _____, has a **documented** _____ or **suspected** _____
(please check)

life threatening allergy to _____ that may require emergency
medical treatment. He/she was last allergy tested on: _____

His/her last significant allergic reaction occurred: _____

Signs and symptoms of this student's allergic reaction that should be noted:

1. _____ 2. _____
3. _____ 4. _____

Follow this Treatment Plan:

1. Administer _____ EpiPen 0.3mg _____ EpiPen Jr. 0.15mg
2. _____
3. _____

I have instructed the student on self-administration of the EpiPen _____ Yes _____ No

Further Instructions:

Date: _____ M.D.

Dear Physician and Parents/Guardians:

We urge that a backup EpiPen be kept in the School Health Room at all times. This EpiPen will be sent on all field trips at the elementary and middle school level to insure the safety of the student. In the high school, students will be responsible for carrying their own EpiPens on field trips. In the elementary school setting, arrangements can be made for an EpiPen to be kept in appropriate locations per the Emergency Care Plan.

Please note that in Lexington, Emergency Medical Services are activated by a call to 911. **In the case of an emergency, the Lexington Fire Department transports to the nearest medical facility with an ED that is “Open” and accepting patients.** Please feel free to discuss an Emergency Medical Plan, or medical situation such as Life Threatening Allergies to food, latex, and stinging insects with the Paramedic Team of the Lexington Fire Department.

****New Emergency Health Care Plans and updates may be submitted throughout the year with medication and/or treatment plan changes.**

Send this completed plan to:

_____ **RN, School Nurse**
_____ **School**

To all parents:

I have read and reviewed the Emergency Health Care Plan formulated by my child’s physician. I agree that it may be placed on file as a part of my child’s school health record, and the necessary information be shared with my child’s teachers and staff. I also give permission for my child’s school nurse to contact the Primary Care Physician or Allergist if further information or clarification is needed regarding my child’s Life Threatening Allergy and the care of my child as stated in this plan.

Date

Parent or guardian signature

I have reviewed the above plan and have incorporated it in the student’s school health record.

Date

School Nurse

RN

My child has been instructed in the self-administration of the EpiPen and has my permission to do so should the need arise.

Date

Parent or guardian signature