SEVERE ALLERGY EMERGENCY CARE PLAN 2025-2026 SCHOOL YEAR
GREENFIELD-CENTRAL COMMUNITY SCHOOL CORPORATION

A **severe** allergy is one that requires emergency medical treatment. If your student requires emergency treatment, including the use of diphenhydramine (Benadryl) or epinephrine, this form must be completed and signed by you and a licensed healthcare provider each school year. If your student does not require medication, you do not need to complete this form, as the allergy is not considered severe if medications are not indicated due to exposure.

Student's Name: _____ Date of Birth: _____

EMERGENCY CONTACTS

Name	Relationship	Telephone
1. _____		
2. _____		

TO BE COMPLETED BY HEALTHCARE PROVIDER

This student has the following allergies that ***require the use of emergency medication***:

_____

Is this student asthmatic? □ Yes (an emergency care plan for asthma must also be completed) □ No

STEPS TO TAKE IF STUDENT HAS INGESTED, BEEN STUNG, OR BEEN EXPOSED TO KNOWN ALLERGEN:

1. Give the following medications (Form 5330F1 must also be completed):

_____
Name of Medication Dose Symptoms

_____
Name of Medication Dose Symptoms

2. Call 911 immediately if epinephrine is administered.
3. Notify parent/guardian and corporation nurse.
4. Other instructions/comments: _____

_____

This student □ Should □ Should Not carry their own emergency medication as listed above. They have been instructed by me, a licensed prescriber, on how and when to administer this medication.

Healthcare Provider's Signature: _____ Date: _____

HCP's Printed Name: _____ Telephone Number: _____

*****THIS IS A 2-SIDED FORM - BOTH SIDES MUST BE COMPLETED FOR PLAN TO BE IMPLEMENTED.*****

TO BE COMPLETED BY THE PARENT/GUARDIAN

In addition to the above instructions from the HCP, I wish to communicate the following information to school personnel regarding my student:

_____

_____

As the parent/guardian of a student with a severe allergy, I understand I should communicate with bus drivers, coaches, extra-curricular sponsors, tutors, etc., regarding my student's condition.

If the HCP has indicated that my student should carry emergency medication, I authorize my student to do so. My student has been instructed on the purpose of and the appropriate method and frequency of use of the prescribed medication. He/she also understands the importance of reporting immediately to the school health assistant at the first sign of an allergic reaction. I understand that 911 will be activated if epinephrine is used by my student or school personnel. I understand that it is **strongly advised** that an extra auto-injector be stored in the clinic even if my student is authorized to carry their auto-injector.

I hereby give permission for the exchange of medical information between the school nurses, health assistants, school principal, and the HCP listed above. I also give permission for clinic personnel to share this medical information with school staff as needed to help protect my student's safety and well-being.

I agree with and wish to implement this emergency care plan for my student.

Parent/Guardian's Signature: _____ Date: _____

Printed Name: _____

TO BE COMPLETED BY SCHOOL PERSONNEL

Date ECP received by clinic personnel: _____

□ ECP reviewed by clinic personnel, PowerSchool Medical Alert updated with allergens, and cafeteria staff notified:

_____ _____

Date Signature

□ ECP Reviewed by Corporation Nurse:

_____ _____

Date Signature

Notes from clinic personnel regarding this plan (if necessary):