NOTE: Parents are to provide the physician's medical management plan to the school ***annually.*** The medical orders, along with the health intake below, assist the school nurse in developing an Individual Healthcare Plan for the student.

Student's Name: _____ **DOB:** ___/___/____ **Grade:** _____ **Today's Date:** ___/___/____

Parent/Guardian 1: _____ **Contact Information:** _____

Parent/Guardian 2: _____ **Contact Information:** _____

Name of physician treating student's allergies: _____ **Phone Number:** _____

Health Insurance: ☐ Private ☐ Medicaid/KanCare ☐ Currently without insurance

Medical alert jewelry worn? ☐ Yes ☐ No **IEP?** ☐ Yes ☐ No **Current 504 Plan?** ☐ Yes ☐ No

Mode of transportation to and from school? _____

Does student participate in before or after school activities? ☐ Yes ☐ No

Does student have a diagnosis of severe allergy from a healthcare provider? ☐ Yes ☐ No

Student is allergic to (check all that apply):

☐ Peanuts ☐ Tree Nuts ☐ Eggs ☐ Milk ☐ Fish ☐ Shellfish ☐ Soy ☐ Wheat ☐ Bee Stings ☐ Latex

☐ Other: _____

Describe student's first allergic reaction:

Age or date: _____

Symptoms: _____

Allergen (if known): _____

How quickly symptoms appeared after exposure: _____

Severity (including need for hospitalization): _____

_____

Describe student's most recent allergic reaction:

Age or date: _____

Symptoms: _____

Allergen (if known): _____

How quickly symptoms appeared after exposure: _____

Severity (including need for hospitalization): _____

_____

Has an epinephrine injection (such as EpiPen) **been given for a past allergic reaction?** ☐ Yes ☐ No

If yes, how many times has epinephrine been administered? _____

More about student's symptoms:

What are student's early signs and symptoms of an allergic reaction? _____

_____

How does student communicate symptoms? _____

_____

What might student say during a reaction? _____

_____

Please check *all* symptoms that student has experienced in the past:

Skin: ☐ Hives ☐ Itching ☐ Rash ☐ Flushing ☐ Swelling (face, arms, hands, legs)

Mouth: ☐ Itching ☐ Swelling (lips, tongue, mouth)

Abdominal: ☐ Nausea ☐ Cramps ☐ Vomiting ☐ Diarrhea

Throat: ☐ Itching ☐ Tightness ☐ Hoarseness ☐ Cough

Lungs: ☐ Shortness of breath ☐ Repetitive cough ☐ Wheezing

Heart: ☐ Weak pulse ☐ Loss of consciousness

Student self-care (Please indicate student's skill level for the following):

Knows what foods to avoid	☐ Yes	☐ No
Asks about food ingredients	☐ Yes	☐ No
Reads and understands food labels	☐ Yes	☐ No
Tells an adult immediately after an exposure	☐ Yes	☐ No
Tells peers and adults about the allergy	☐ Yes	☐ No
Firmly refuses a problem food	☐ Yes	☐ No
Knows how to use emergency medication	☐ Yes	☐ No
Has administered emergency medication to self in the past	☐ Yes	☐ No

NOTE: Self-care at school will be determined in consideration of the above information, healthcare provider orders, and school nurse ongoing assessment of student's skills.

Meal plan:

Will student participate in breakfast at school?_____

Will student bring lunch, eat school lunch, or both?_____

Does student regularly eat snacks at school?_____

Classroom snacks/birthday treats from other students: We recommend that parents/guardians provide a supply of individualized snacks for early childhood and younger elementary-age students with known food allergies. Please indicate your preference by ***selecting one*** of the following:

_____ I will provide ***all*** of my student's food. He/she **is not to eat** other snacks/treats at school unless I am present or have provided ***prior written approval*** specific to the item.

_____ My student knows about foods to avoid and **may eat** snacks/treats provided by others.

Does student have family, peer, and community support systems? ☐ Yes ☐ No

Describe student's response and current coping/adaptation to having severe allergies: _____

_____

Parent/Guardian Signature: _____ **Date:** _____