INDIVIDUAL HEALTH PLAN / EMERGENCY CARE PLAN FOR STUDENT WITH *SEVERE ALLERGY*

TO BE RENEWED EACH SCHOOL YEAR
(If you need assistance completing this form, contact the Licensed School Nurse.)

Student Name _____ Birth Date _____

School _____ Grade _____ Teacher _____ School Year _____

According to our records, your child has a severe allergy which requires emergency medication and/or cares. Completion of this form will keep your child's health record current.

1. My child still has this allergy:
☐ **YES Complete form, sign & date back, and return to your child's school.**
☐ **NO Parent/Guardian signature: _____ Date:_____**
(If "No" is checked, do not fill out the remainder of the form, sign and return to your child's school.)

2. My child is allergic to:_____
3. Reaction occurs from: ☐ ingestion ☐ contact ☐ inhalation ☐ insect sting
4. My child has had a life threatening, anaphylactic reaction to this allergen: ☐ YES ☐ NO
5. Does your child also have asthma? ☐ YES (Higher risk for severe allergic reaction) ☐ NO

SIGNS OF AN ALLERGIC REACTION INCLUDE:
(Please check symptoms most common to your child.)

__LUNGS	__HEART	__THROAT	__MOUTH	__SKIN	__GUT	__OTHER
						
LUNG	**HEART**	**THROAT**	**MOUTH**	**SKIN**	**GUT**	**OTHER**
Shortness of breath, wheezing, repetitive cough	Pale or bluish skin, faintness, weak pulse, dizziness	Tight or hoarse throat, trouble breathing or swallowing	Significant swelling of the tongue or lips	Many hives over body, widespread redness	Repetitive vomiting, severe diarrhea	Feeling something bad is about to happen, anxiety, confusion

The severity of symptoms can quickly change. *All above symptoms can progress to a life-threatening situation.
6. History of reaction (date of last reaction / signs & symptoms of reaction): _____
_____
7. Does your child recognize these signs and symptoms? ☐ YES ☐ NO
8. Will your child require a rescue medication to be given at school? ☐ YES ☐ NO
If yes, epinephrine auto-injector will be kept: ☐ In health office ☐ With student (grades 5-12 only)
Epinephrine expiration date: _____
9. Health Care Provider Name: _____ Phone # _____

10. Emergency Contacts *(list in order of who to call first)*
Name: _____ Relationship: _____ Phone:_____
Name: _____ Relationship: _____ Phone:_____

FOOD ALLERGIES
My child can identify all foods that should be avoided and can self-manage their food intake at school:
☐ YES ☐ NO (explain): _____
*It is the responsibility of the parent/guardian to review lunch menus and coordinate with the health office, dietary, and classroom teacher on how to manage mealtime, classroom snacks, and art projects. **The school cannot guarantee that the facility or dining area will be allergen free.*

SCHOOL ACTION/EMERGENCY PLAN (if exposure to allergen occurs):

****If student has an epinephrine auto-injector for a bee sting allergy, it will be immediately given if stung****

1. Give prescribed medications if available. If symptoms do not improve, or symptoms return, additional dose of
2. epinephrine can be given (if ordered by a licensed prescriber and authorized by parent/guardian). Call 911. Tell emergency dispatcher the person may be having anaphylaxis.
3. Lay the person flat, raise legs, and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side. Calm and reassure student.
4. Contact parents/guardian.
5. Emergency transportation to hospital is recommended for further monitoring.

(The Consent Form for Administration of Emergency Allergy Medication During the School Day for an epinephrine auto-injector must be completed and signed by the health care provider and parent.)

SCHOOL MANAGEMENT PLAN / PARENT/GUARDIAN AUTHORIZATION

☐ No epinephrine auto-injector at school. Follow School Emergency Action Plan.

☐ Student needs help with allergy signs and symptoms; epinephrine auto-injector will be administered as ordered. The epinephrine auto-injector must be properly labeled for the student.

1. I understand that this information may be shared with all school staff who work directly with my child
2. I authorize the Licensed School Nurse/designee to exchange information with my child's health care provider related to his/her allergy plan.
3. I will contact the Licensed School Nurse/designee if a change in the current plan is indicated.
4. Field trips - I give permission for a trained teacher/school personnel to administer the medication on a field trip.
5. I will provide this medication in the original, properly labeled pharmacy container and u*nderstand the school does not have stock epinephrine auto-injectors.*
6. I release school personnel from any liability in relation to the administration of this medication at school. (Administration of this medication will not necessarily be done by the Licensed School Nurse.)
7. **I understand if my child rides the school bus and/or participates in before or after school activities, it is my responsibility to inform the staff/bus company of my child's health plan.**

OR

STUDENT SELF-MANAGEMENT PLAN / PARENT/GUARDIAN AUTHORIZATION (for grades 5-12 only)

☐ Student can self-manage allergy signs and symptoms, no epinephrine auto-injector at school.

- Student will go to the health office if an allergic reaction occurs, and 911 and parent will be called.

☐ Student can self-manage allergy signs and symptoms and may independently carry/use **epinephrine auto-injector at school.**

- The health office staff will assess the student's knowledge and skills to safely possess and use his/her epinephrine auto-injector in a school setting. If non-compliance or a change in status occurs, the Licensed School Nurse will contact parent/guardian to discuss a new Agreement.
- *Students who self-manage their allergy will NOT be monitored by school personnel on a daily basis*
    1. If epinephrine auto-injector is needed at school, I request my child self-manage his/her allergy and be responsible for carrying the epinephrine auto-injector and administering as prescribed.
    2. My child will notify a school staff member if he or she administers epinephrine so 911 can be called.
    3. I understand that this information may be shared with all school staff who work directly with my child.
    4. I authorize the Licensed School Nurse/designee to exchange information with my child's health care provider related to his/her allergy plan.
    5. I will contact the Licensed School Nurse/designee if a change in the current plan is indicated.
    6. I understand the school does NOT have stock epinephrine auto-injectors, and emergency rescue medication is not available if the student fails to bring his/her epinephrine auto-injector or keep it at school or in his/her bag.
    7. ***I understand that my child will inform all staff, including teachers, coaches, and bus drivers, of his/her allergy, health plan, and will be responsible to carry the epinephrine auto-injector on field trips.***

Parent/Guardian Signature _____ **Date** _____

SCHOOL NURSE SIGNATURE:_____ Date:_____