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, and return to your child's school.
   - ◯ **NO** If "No" do not fill out the remainder of the form, but 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.)

☐ MOUTH	☐ SKIN	☐ GUT	☐ THROAT	☐ LUNGS	☐ HEART	☐ OTHER
						
itching & swelling of the lips, tongue, or mouth	hives over body, widespread redness, itchy	nausea, abdominal cramps, vomiting, diarrhea	tight or hoarse throat, trouble breathing or swallowing	shortness of breath, wheezing repetitive cough	pale or bluish skin, faintness, weak pulse, dizziness	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 (secondary only)
   Epinephrine expiration date: _____
9. Health Care Provider Name: _____ Phone # _____
10. Emergency Contacts (*list in order of who to call first*)

Name: _____ Relationship:_____ Phone:_____Phone:_____

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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 well be immediately given if stung*

1. Give prescribed medication if available. If symptoms do not improve, or symptoms return, additional dose of epinephrine can be given if ordered by a licensed prescriber and authorized by parent/guardian. (*The Consent Form for Administration of Emergency Allergy Medication During the School Day must be completed and signed by the health care provider and parent/guardian.)*
2. 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 parent/guardian.
5. Emergency transportation to hospital is recommended for further monitoring.

PARENT/GUARDIAN AUTHORIZATION

Select one

- ◯ No epinephrine auto-injector at school. Follow 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.
- ◯ Student can self-manage allergy signs and symptoms, **no epinephrine auto-injector at school.**
  - Recommended for secondary students only.
  - Student will go to the health office if 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 an skills to safely possess and use the 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.
  - My child will notify a school staff member if he/she administers epinephrine so 911 can be called.

BY SIGNING THIS DOCUMENT THE PARENT/GUARDIAN AGREE TO THE FOLLOWING:

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 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.
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.

Parent/Guardian Signature _____ **Date** _____

Licensed School Nurse Signature _____ **Date** _____