MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT
SEVERE ALLERGY INDIVIDUAL HEALTH PLAN 20____ - 20____

Name:	**Date:**	
Birth Date:	**Student # :**	
School:	**Grade:** **Teacher:**	
Asthmatic? Yes * No If yes, increased risk for severe reaction.		
Severe Allergy to:		

If you suspect a severe allergic reaction, immediately administer Epinephrine and call 911

Allergy Symptoms:

MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
THROAT	Sense of tightness in the throat, hoarseness, and hacking cough
GUT	Nausea, stomachache/abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive coughing, and/or wheezing
HEART	"Thready" pulse, "passing out," fainting, blueness, pale
GENERAL	Panic, sudden fatigue, chills, fear of impending doom
OTHER	Some students may experience symptoms other than those listed above

ACTION PLAN

- **GIVE MEDICATION AS ORDERED ABOVE, AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES.**
  *** NOTE TIME _____AM/PM (Epinephrine given) * NOTE TIME _____AM/PM (antihistamine given)**
- **CALL 911 IMMEDIATELY. 911 must be called WHENEVER Epinephrine is administered.**
- **DO NOT HESITATE to administer Epinephrine and to call 911, even if the parents cannot be reached.**
- Advise 911 that student is having a severe allergic reaction and Epinephrine is being administered.
- An adult trained in CPR is to stay with student to monitor and begin CPR if necessary.
- Call the School Nurse or health Services Main Office at _____.

*Student to remain with a CPR trained staff member at location where symptoms began until EMS arrives.
*Notify the administrator and parent/guardian.
*Dispose of used auto-injector in "sharps" container or give to EMS along with a copy of Care Plan.

MEDICATION ORDERS (must be filled out by licensed health care provider and include a prescription)

EpiPen® (0.3) or EpiPen (.15) Other	Side Effects:
Repeat dose of EpiPen®: Yes No	If YES, when
Antihistamine:	Side Effects:

- Is it medically necessary for this student to carry an Epi-Pen® during school hours? Yes No
- Student may self-administer Epipen® Yes No
- Student has demonstrated use to LHCP. Yes No

Licensed Health Care Provider's Signature:	Date: Fax:
Licensed Health Care Provider's Printed Name:	Phone:

Emergency Contact Numbers:	
Parent/Guardian: a. b. email:	**Home phone:** Work: Cell: Work: Cell:
Emergency Contact: Relationship:	**Phone:**
Primary Care Physician:	**Phone:**
School Nurse: **Email:**	**Phone:** **Fax:**

Other health concerns:	
Other Medications:	**Dose/Time:**
Dietary concerns/restrictions:	
Parent Signature	**Date:**

Individual Considerations:

Bus-Transportation should be alerted to student's allergy

- Student will sit at front of bus
- Students are to be alerted that eating is not allowed on the bus

Field Trip Procedures:

EpiPen and Health Care Plan should accompany student during any off campus activity.

- ☐ The student should remain with the teacher or parent/guardian/representative during the entire field trip Yes No
- ☐ A staff member, parent, or parent representative on trip must be trained regarding auto-injector use and health care plan.
- ☐ Other (specify):

Classroom: This student is allowed to eat only the following foods:

- ☐ Those in manufacturer's packaging with ingredients listed and determine allergen free by the parent.
- ☐ Those approved by parent.
- ☐ Alternative snacks will be provided by parent/guardian to be kept in the classroom.
- ☐ Classroom projects should be reviewed by teaching staff to avoid specific allergens.

Other (specify):

- ☐ Middle school or high school students will be making his/her own decision.
- ☐ Teachers, Substitute teachers and Specialists will be informed of Life threatening Food Allergy.

Cafeteria:

- ☐ **No Restrictions**
- ☐ Student will sit at a specified allergy table.
- ☐ Student will sit at the classroom table at a specified location.
- ☐ Specified table will be cleaned according to procedure guidelines.
- ☐ Nutrition services staff should be alerted to the student's allergy.

Health Care Plan posted in cafeteria in a private place Yes No

Parent/Guardian Signature: I Agree to allow the sharing of medical information with Provider and School Staff for the health and safety of my child. _____ Date: _____

Copies:

Parent
Teacher
Library
Transportation
Food Services
Nurse's Office
Guidance

db
MCCSDsevallergy