RANKIN COUNTY SCHOOL DISTRICT SCHOOL ALLERGY HEALTH PLAN

DATE RECEIVED ____ / ____ / ____

TO BE COMPLETED BY PARENT OR GUARDIAN

Name _____ Age _____ Date of Birth _____

School _____ Teacher _____ Grade _____

Emergency Contact Name _____ Phone _____

IMPAIRMENT

Allergy _____ Date of Diagnosis _____

Brief description of reaction to allergen and frequency of reactions:

List all symptoms related to the allergic reactions:

List any known triggers of allergic reactions:

List any restrictions student must follow while at school:

List any medications:

Will the student need any medications administered at school? ☐ Yes ☐ No

If yes, please complete the Consent for Medication at School form and provide the medication to the school.

Health Care Provider _____ Health Care Provider Phone _____

TO BE COMPLETED BY THE SCHOOL WITH PARENT/GUARDIAN

STUDENT/GUARDIAN WILL:

1. Avoid known allergens.
2. Take all prescribed medications and follow plan of care.
3. Follow up with health care provider as appropriate.
4. Alert school staff immediately of any signs/symptoms of an allergic reaction.

SCHOOL WILL:

1. Maintain student safety by monitoring for symptoms of health concerns.
2. Encourage student to follow plan of care.
3. Contact parent / guardian concerning student health concerns.
4. Call 911, if needed.

Health Care Provider - Name (Print)	Health Care Provider - Signature
Parent/Guardian - Name (Print)	Parent/Guardian - Signature
School Representative - Name (Print)	School Representative - Signature