



Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956

Picture

Allergy Plan

Student _____ Date _____ Grade _____

Date of Birth _____ School _____ Teacher _____

Address _____ City _____ Zip Code _____

Emergency Contacts:

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

Allergy to:

Allergy by:

☐ Ingestion ☐ Touch ☐ Airborne ☐ Insect sting

History of Anaphylaxis?

☐ Yes ☐ No

History of Asthma?

☐ Yes ☐ No

For **ANY SEVERE** symptoms:



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION

of symptoms from different body areas

1) **INJECT EPINEPHRINE IMMEDIATELY**

2) **CALL 911**

3) Alert emergency contact

4) Give antihistamine if ordered below

5) Give inhaler if ordered below

6) Lay person flat, raise legs, keep warm. If student has difficulty breathing or is vomiting, sit up or lie on side.

7) After 5 min, if symptoms do not improve or worsen, give second epinephrine.

For **MILD** symptoms from a **SINGLE** body system:



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

1) Give antihistamine if ordered below

2) Monitor student

3) **If symptoms worsen OR involve more than one body system area GIVE EPINEPHRINE and CALL 911**

4) Alert emergency contact

Student Name: _____ Student DOB: _____

Emergency Response:

☐ Check this box if the student needs **Epinephrine Immediately** due to Extreme Anaphylactic reaction even if symptoms are not present.

Medication To be given:

Student Weight (lbs): _____

Antihistamine Type: _____ Dose: _____ Expiration Date: _____

Epinephrine Type: _____ Dose: _____ Expiration Date: _____

Other (Inhaler) Type: _____ Dose: _____ Expiration Date: _____

Student with FOOD allergies only, please complete the following:

Does your child need to sit at a Nut Aware/alternative lunch table? ☐ YES ☐ NO

Complete the Chartwells Dietary Restriction Form (must be completed and signed by physician to receive alternative food options or special accommodations from school).

Parent consent for management of health condition while at school or other school related activities

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature _____ Date _____

Physician Information

Print Name of Provider _____ Clinic Name _____

Phone Number _____ Fax Number _____

Address _____

Signature of Provider _____ Date _____

Provider NPI # _____

By signing this form you are acknowledging this medication/Health plan is medically necessary for school