MISSISSINEWA COMMUNITY SCHOOLS

HEALTH SERVICES

NON-FOOD ALLERGY CARE PLAN

Allergy:_____

Name:_____ DOB:_____ Grade:_____

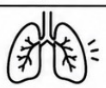
Parent/Guardian Name: _____ Phone Number:_____

Emergency Contact 1:_____ Phone Number:_____

Emergency Contact 2:_____ Phone Number:_____

Asthma: ☐ YES ☐ NO

MILD REACTION	
Symptoms are usually non-life-threatening and may include:	
	**SKIN** Hives, rash, itching, redness, or mild swelling.
	**NOSE** Runny nose, sneezing, or nasal congestion.
	**EYES** Itchy, watery, red, or puffy eyes.
	**DIGESTIVE** Nausea, mild stomach discomfort or cramps.
	**OTHER** Mild headache or feeling unwell.

SEVERE REACTION (ANAPHYLAXIS)	
Symptoms are serious, can develop quickly, and may be life-threatening:	
	**SKIN / FACE** Hives over large areas, severe swelling of face, lips, tongue or throat.
	**AIRWAY / THROAT** Trouble breathing, wheezing, hoarseness, or tightness in throat.
	**LUNGS** Shortness of breath, persistent coughing, or noisy breathing (wheezing).
	**CIRCULATION** Dizziness, fainting, rapid or weak pulse, or low blood pressure.
	**DIGESTIVE** Severe nausea, vomiting, diarrhea, or severe abdominal pain.

ACTION FOR MINOR REACTION

Symptom(s):_____

Treatment:_____

If condition does not improve within 10 MINUTES, follow steps for MAJOR REACTION below.

*ACTION FOR MAJOR REACTION *

Symptom(s):_____

Treatment:_____

Has emergency medical treatment been required in the past year for allergies:_____

If Yes, Explain:_____

CONTINUED ON BACK

Is EpiPen prescribed for the treatment of a reaction: ☐ Yes ☐ No

Administer EpiPen if the following symptoms are observed:_____

_____

If EpiPen is required:

Please Check One:

☐ Administer ***before*** symptoms occur & immediately upon exposure.

☐ Administer ***if*** symptoms occur.

EpiPen Auto Injector Dosage:

☐ Adult 0.3 mg

☐ Junior 0.15 mg

Please Check One:

☐ Student has been instructed on the proper way to administer EpiPen and may carry their own pharmacy labeled EpiPen at all times.

☐ EpiPen is to be kept in the Clinic and administered by trained staff.

Physician's Name:_____Date_____

Physician's Signature:_____Phone Number:_____

PARENTAL CONSENT FOR EPIPEN

Student Name:_____ Grade:_____

I, the parent or guardian of the above named student, authorize properly trained and Staff Members and School Bus Drivers of Mississinewa Community Schools Corporation to administer my child's EpiPen according to the manufacturer's instructions and physician's orders.

I understand that if the EpiPen is administered, 911 will be called and EMS will be asked to evaluate the effectiveness of the EpiPen. The school nurse and an administrator will also be notified.

I further understand that every attempt shall be made to contact myself, another parent/guardian, or designated emergency contact persons.

Parent/Guardian Signature:_____

Date:_____