

LIFE-THREATENING ALLERGY INDIVIDUAL HEALTH CARE PLAN

Effective for school year 20__ - 20__ only and MUST be renewed each school year.

This page is to be completed by PARENT/GUARDIAN

Student's Name: _____ Age: _____
 Teacher: _____ School: _____ Grade: _____

Parent(s)/Guardian(s) Name and Emergency Contact Information:

Parent/Guardian Name: _____
 Phone(____) _____ (Hm/Wk/Cell)
 Emergency Contact Name: _____
 Phone(____) _____ (Hm/Wk/Cell)

List Known Allergies: _____

Please check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Student is aware to avoid allergen | <input type="checkbox"/> Notify parent of ANY reactions |
| <input type="checkbox"/> Student is aware of allergic reaction symptoms? | <input type="checkbox"/> Notify parent ONLY of major reactions |
| <input type="checkbox"/> Student to always carry emergency kit | <input type="checkbox"/> Notify school nurse of all reactions |
| <input type="checkbox"/> Student can self-administer emergency kit | <input type="checkbox"/> Student is UNABLE to self-administer emergency kit |

Other instructions/comments: _____

List symptoms of a **MINOR REACTION**: _____List symptoms of a **MAJOR REACTION**: _____

Medication	Dose	Route	When to Use	How soon can it be repeated
			<input type="checkbox"/> Minor <input type="checkbox"/> Major	
			<input type="checkbox"/> Minor <input type="checkbox"/> Major	
			<input type="checkbox"/> Minor <input type="checkbox"/> Major	

(HEA-F062 Authorization for Medication to be Taken During School Hours must be completed for each medication)***911/EMS MUST BE NOTIFIED IF AN EMERGENCY KIT IS ADMINISTERED AT SCHOOL***

☐ I DO ☐ I DO NOT request that my child, named above, be permitted to carry and self-administer emergency medication as ordered by the healthcare provider.

☐ I understand that the school may suspend or revoke my child's possession and self-administration privileges if he/she misuses the emergency kit or makes it available for usage by another person.

☐ The secure location (on student's person) where emergency kit will be kept:

☐ **backpack** ☐ **sports bag** ☐ **purse** ☐ **binder** **OTHER:** _____

I, (print name) _____, acknowledge that the school and its employees shall incur no liability as a result of any injury sustained by my child, or any other person, as a result of possession or self-administration of the emergency kit. I shall also indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the emergency kit.

Parent/Guardian Signature: _____ Date _____

School Nurse Signature: _____ Date _____

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Student's Name: _____ School: _____ Date: _____

Please answer the following questions:

1. Is it necessary for school health services to send home a letter notifying your child's classroom about your child's allergy to decrease the chances the allergen will be brought to school by a classmate?

Yes ☐ No ☐

2. Is it necessary for school health services to provide allergy education to classmates and staff?

Yes ☐ No ☐

3. Is it necessary for your student to sit at the allergen-aware table in the cafeteria and classroom?

Yes ☐ No ☐

4. Does your student eat school-provided lunch?

Yes ☐ No ☐

If yes, please complete the Special Needs in School Nutrition Program form (CHN-F017) and return to the school nurse.

- ☐ Please note without medical documentation on file, the school cafeteria will not monitor your student's food selections.

5. Does your student participate in before or after school sponsored activities such as clubs, or sports programs?

Yes ☐ No ☐

If **yes**, does your student have written physician authorization to self-carry/administer emergency medications on file with the school nurse (form HEA-F062)? Yes ☐ No ☐

- ☐ If self-carry is **not** authorized by your Medical Provider, please indicate plan of action for an emergency during a before or after school sponsored event.

6. Does your student ride the school bus?

Yes ☐ No ☐

If **yes**, does your student have a written physician authorization to self-carry/administer emergency medications on file with the school nurse (form HEA-F062)? Yes ☐ No ☐

- ☐ If self-carry/administration is **not** authorized by a Medical Provider, then 911 will be called for any emergency on the school bus.

7. Does your student require preferred seating on the bus? Yes ☐ No ☐

*The classroom teacher will notify you in advance of parties that will include food or snacks. You may send in allergen-free snacks for your student.

Additional comments/information: _____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

District RN Signature: _____ Date: _____