

District 4J Schools
HEALTH SERVICES

Student Name _____ School _____

Date of Birth _____ Date _____ Grade _____

SEVERE ALLERGY ASSESSMENT AND CARE PLAN

You have checked on school records that this student has a **severe allergy**. It is important to have current health information and direction when she/he needs help at school. Please complete this form and return it to your child's school, so that appropriate instructions may be given to school personnel. **If epinephrine is prescribed, the parent/guardian is responsible for providing a pre-measured dose (eg. Epi-pen) to the school for emergency use.** Your school nurse is available for consultation.

CHECK ANY SEVERE ALLERGIES YOUR STUDENT HAS:

a. _____ Insect Stings (list type) _____

b. _____ Foods (list type) _____

c. _____ Pollens: usually reactions occur: _____ spring _____ summer _____ fall _____ winter

d. _____ Dust _____ Grass _____ Animals (list type) _____

e. _____ Other (list) _____

CHECK SYMPTOMS USUALLY PRESENT DURING ALLERGIC REACTION BY PLACING LETTER(S) OF THE ALLERGIES CHECKED ABOVE BESIDE THE SIGNS LISTED BELOW

_____ difficulty breathing _____ rash
_____ difficulty in swallowing _____ nausea
_____ loss of consciousness _____ flushed or unusually pale skin color
_____ swelling, describe below _____ other (list) _____

How much swelling/where? _____
Has hospitalization/emergency room visit been needed in past for allergies? _____ No _____ Yes

Which allergy, when and for what symptoms?) _____

Allergies are currently be treated by Dr. _____ Phone: _____

Does your child ride the school bus? _____ No _____ Yes

Does your child participate in school sports? _____ No _____ Yes

ARE MEDICATIONS NEEDED TO CONTROL/TREAT THE ALLERGY(IES)? ___ No ___ Yes

MEDICATIONS **AMOUNT TAKEN** **HOW OFTEN AND FOR WHAT SIGNS**

1. _____

2. _____

3. _____

(Circle the number of any of these medications to be taken at school.)

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Student Name _____

THE USUAL CARE PLAN AT SCHOOL FOR A STUDENT HAVING A SEVERE ALLERGIC REACTION IS TO:

1. Assist student with the prescribed medication. Whenever Epinephrine is given call 911.
2. Stay with the student. Watch for inadequate breathing; signs of shock; unusual swelling; and if observed, call 911/EMS.
3. Call parent immediately.
4. Additional steps: _____

Parent/Guardian Contact #1

Emergency Contact #2

Emergency Contact #3

Name _____
Relationship _____
Address _____
Phone: (H) _____ (W) _____
Cell _____

Name _____
Relationship _____
Address _____
Phone: (H) _____ (W) _____
Cell _____

Name _____
Relationship _____
Address _____
Phone: (H) _____ (W) _____
Cell _____

AMBULANCE PERMIT

I give consent for the school principal, school nurse, or other school personnel to use their judgment in securing further medical aid and to call an ambulance to take my (son, daughter) _____ to _____ Hospital in case parent/legal guardian cannot be reached.

The above information may be shared with ambulance personnel. **PERMISSION: __ YES __ NO**

To provide for your child's safety and educational experience the above information will be shared with school staff, included in your child's school health record and may be shared electronically.

Signature of Parent/Guardian

Date (Valid One Year)

RETURN THIS FORM TO THE SCHOOL

DATE

SIGN / INITIAL

STUDENT COMPUTER SYSTEM ENTRY _____

INFORMATION SHARED WITH STAFF _____

Additional notes: _____

