

ALLERGY INDIVIDUAL HEALTH PLAN

(Parent/guardian to complete this form)

STUDENT NAME _____ DOB _____ SCHOOL _____

GRADE _____ TEACHER _____ SCHOOL YEAR _____

PARENT/GUARDIAN _____ BEST CONTACT/PHONE NUMBER _____

PHYSICIAN _____ PHONE _____

ALLERGY SPECIALIST _____ PHONE _____

What is your child allergic to (type of food, specific medications, type of insect, etc.)?

Please describe what happens with your child during an allergic reaction (symptoms, etc.):

Does your child have a doctor's order for Benadryl or Zyrtec (generic: Cetirizine) to be given at school and is this medication at school? Yes No

Does your child have a doctor's order for an injectable Epinephrine (example: Epi-pen, Epi-pen Jr., Auvi-Q, or generic Epi-pen) to be given at school, and is this medication at school? Yes No

Has your child been to an emergency room due to an allergic reaction in the past year? Yes No
If yes, please describe:

Has your child had a severe allergic reaction that required injectable epinephrine, such as an Epi-pen, be given in the past?
 Yes No
If yes, when?

In the event that you cannot be reached, please list the name(s) and phone number(s) of persons who are familiar with your child's allergy and have knowledge of how to manage an allergic reaction. *Please also add this person(s) to your child's pick-up list in case they may need to pick your child up from school due to their allergy.*

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Is there anything else you would like school staff to know about your child's allergy/allergies?

PLEASE NOTE: We recommend an Emergency Action Plan, completed by a doctor, for all children with a severe allergy. Please review the back of this form for steps school staff may take in the event of a medical emergency. These will be followed if your child does not have an Emergency Action Plan at school for this condition.

- I give permission for my child, _____, to receive care for the medical condition listed above by designated school staff.
- School nurse may share information regarding this condition with my child's doctor.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

SCHOOL NURSE SIGNATURE _____ DATE _____