

M.S.D. Student Health Services

MNE Fax: 260-569-6838

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School Year _____

STUDENT HEALTH SERVICES PLAN OF CARE - ALLERGIES

ALLERGY TO: _____

Student Name: _____ Date of Birth: _____ Grade: _____

Parent/Guardian Name: _____ Home phone #: _____ Work #: _____ Cell #: _____

Emergency Contact #1: _____
Name Relationship Phone #

Emergency Contact #2: _____
Name Relationship Phone #

Asthma: Yes No

◆ SIGNS OF AN ALLERGIC REACTION ◆

Systems:

Symptoms:

- **MOUTH** itching & swelling of the lips, tongue, or mouth
- **THROAT*** itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- **SKIN** hives, itchy rash, and/or swelling
- **GUT** nausea, abdominal cramps, vomiting, and /or diarrhea
- **LUNG*** shortness of breath, repetitive coughing, and/or wheezing
- **HEART*** "thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

◆ ACTION FOR MINOR REACTION ◆

Symptom(s) are: _____

Do/Give (dosage): _____

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

◆ ACTION FOR MAJOR REACTION ◆

Symptom(s) are: _____

Do/Give (dosage): _____

Has emergency medical treatment been required in the past year for allergies: Yes No

Explain: _____

Administer Epi-Pen if the following symptoms are observed: _____

If Epi-Pen is required: Administer **before** symptoms occur & immediately upon exposure Yes No
Administer **if** symptoms occur Yes No

Epi-Pen Auto Injector Dosage: Adult 0.3mgIm Yes No
Junior 0.15mgIm Yes No

Student has been instructed in the proper way to administer Epi-Pen, when to give, and **may carry** their own pharmacy labeled Epi-Pen at all times. Yes No

Physician's Printed Name	Physician's signature	Phone #	Date

Epi-Pen (**provided by parents**) should be kept in Health Room and administered by trained staff. Yes No

Parental Consent for Epi-Pen

Student Name: _____ Grade: _____ School: _____

I, the parent guardian of the above named student, authorize properly trained and oriented Staff Members and School Bus Drivers of MSD of Wabash County School Corporation to administer my student's Epi-Pen according to the manufacturer's instructions and physician's orders.

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

I further understand that every attempt shall be made to contact parent/guardian or designated emergency contact person.

Printed Name of Parent or Guardian	Signature	Date