M.S.D. Student Health Services

LAF Fax: 260-569-6837 MNE Fax: 260-569-6838 NHS Fax 260-569-6839
SCE Fax: 260-569-6841 SES Fax: 260-569-6842 SHS Fax: 260-569-6843

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

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

Physician's printed name	Physician's signature	Phone #	Date

****

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