Anaphylaxis (Severe Allergic Reaction) Individual Health Plan School Year: _____ Grade: ___

Student Name_____DOB_____
Parent/Guardian_____Phone_____
Emergency Contact_____Phone_____
Treating Physician_____Phone_____

Allergy to:_____ Dx of Asthma? ❒Yes ❒No

Severity Classification
- ❒ Mild Intermittent
- ❒ Mild Persistent
- ❒ Moderate Persistent
- ❒ Severe Persistent

Triggers
- ❒ Peanuts
- ❒ Tree nuts
- ❒ Shellfish
- ❒ Latex
- ❒ eggs
- ❒ milk
- ❒ medication
- ❒ animals
- ❒ Insect Stings (list)_____
- ❒ All dairy
- ❒ fish
- ❒ other _____

School Nutrition Modification Evaluation Form Must Be Completed by Prescribing Physician For ALL Dietary Modifications

Mild to Moderate Allergic Reaction	Action	Medication MD-Please Specify
❒ swelling of lips, face, eyes ❒ hives or welts ❒ abdominal pain ❒ vomiting ❒ other_____	1. stay with child and call for help 2. give medication (if prescribed) -contact parent/guardian	❒Antihistamine: _____ _____ ❒Other: _____

Anaphylaxis—Severe Reaction or No Improvement

- ❒ **difficulty/noisy breathing**
- ❒ **swelling of tongue**
- ❒ **cold, clammy, sweaty skin**
- ❒ **swelling/tightness in throat**
- ❒ **pale and floppy (young children)**
- ❒ **flushed face**
- ❒ **difficulty talking and/or horse voice**
- ❒ **loss of consciousness**
- ❒ **other**_____

Action / Medication

❒**Epinephrine** _____via auto injector

Call 911 & Contact the Parent/Guardian

Location of medication: ❒ Health Unit ❒ Emergency Action Medication must be with student at all times, *either on their person or with an accompanying adult*

Administration of medication: ❒ School Nurse or trained unlicensed school personnel ❒ Self administration with adult supervision

❒ **Independent Self Administration—**it is my professional opinion that this student is able to carry above prescribed medication with them at all times—during the school day, on field trips, and while participating in before or after school clubs/events/athletics. He/she has been instructed on the indication for medication usage and the method of administration.

Please Note: *The school nurse does not always attend field trips or after school events/clubs/athletics. For this reason non-medical, unlicensed school staff members are trained to administer medication. Student authorized for independent self administration of medication are not monitored by school staff, however school staff are available for emergency response during all school sponsored activities.*

Prescription medication or treatment daily at school for this condition: _____

Prescription medication or treatment daily at home for this condition: _____

During a field trip, scheduled daily medication:
- ❒ requires a trained staff member to administer medication
- ❒ is authorized to carry and self administer medication

X _____ _____ _____

Physician or Authorized Healthcare Provider Signature ***Telephone Number*** ***Date Signed***

I am the parent/guardian of the above named student and give consent and permission for the information on this form to be shared with teachers, principals, and other school personnel that have direct contact with my child for the current school year. I understand that a trained staff member may administer prescribed medication and/or assist my child to comply with his/her physician's prescribed medications or treatments if needed. If my child's physician gives authorization for my child to carry and self-administer his/her medication, I consent and understand that medication independently self administered is not monitored by school or health department staff. I agree to provide the necessary prescribed medication or treatment supplies and agree to notify the school nurse immediately of any changes.

The school nurse shall contact the student's Parent/Guardian to discuss any concerns regarding the student's care which might require medical follow-up and/or shall contact the health care provider to obtain current information verbally when necessary to manage the student's condition at school. I understand that the Powell County Board of Education Medication Policy and Procedures (09.2241) are readily available for me to read.

I hereby agree to release and hold Powell County Schools free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment described by me or prescribed by my child's physician. I have read and understand this consent. I sign it voluntarily and with full knowledge of its significance.

X _____ _____

Parent/Guardian Signature ***Date Signed***