Individualized Health Care Plan for Life-Threatening Allergies

To be completed by the student or parent if the child is too young:

Students Name_____ Grade_____

I have allergy/s to _____. I know I need to avoid _____.

The reaction/s I have are: _____

_____

_____

I know my care is _____

_____

_____

The medication I need is _____

How is the medication given? _____

The medication located (where) _____. The back up location for my medication is _____.

I do have/ do not have permission to carry my medication. _____

I will carry the medication (where) _____. The back up location for my medication is _____.

I will tell the responsible adult immediately if I have come in contact will the allergen or I am having a reaction.

Student signature_____ Date_____

To be completed by the Parent

_____ (Student's Name) has severe allergies to _____. This allergy may cause _____ in my child. I have provided to the school the physician's medication permission and instructions. I want these instructions carried out. I have instructed my child of about his/her allergy, how to avoid exposure to the allergen, care to take if exposure occurs. I will provide the medication with proper pharmacy label and be aware of the expiration date to replace the medication. I hereby request treatment of the medication specified above to be given to the above named student, and that someone may give the medication other than a medically trained person. I know 911 will be called with the use of ephinephine. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein. I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, an employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent Signature_____ Date_____

To be completed by the school

____ Instruction has been given on the medication order and the parent's instruction of care.

____ The students' responsible adults are instructed in the allergy, symptoms, and avoidance, care, and treatment.

____ Epinephrine auto injected device locations are known.

____ If the Epipen is used 911 with advance life support will be called.

Principal_____ School Nurse or Health Consultant_____

Teacher_____ PE _____

(If appropriate) Before & After Program Coordinator _____

Coach _____ Date_____

Physician _____ Date _____

Medication Permission Form for Life-Threatening Allergies

ALLERGY TO: _____

Student's
Name: _____ D.O.B. _____ Teacher _____

Asthmatic: _____**Yes*** _____ **No** ***High risk for severe reaction**

THIS CHILD'S 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 about the face or extremities
·**GUT**	nausea, abdominal cramps, vomiting, and/or diarrhea
·**LUNG***	shortness of breath, repetitive coughing, and/or wheezing
·**HEART***	"thread" 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

If only symptom(s) are: _____, give _____
medications/dose/route

_____

Then call:
1. Mother _____, Father _____, or emergency contacts.

2. Dr. _____ at _____

This child may/ may not carry this medication. Name where; school, sports events, out of school activities.
If condition does not improve within 10 OR ___minutes follow the steps for "Action for Major Reaction" below:

ACTION FOR MAJOR REACTION
If ingestion is suspected and/or symptom(s) are: _____ give

_____ **IMMEDIATELY!**
Medications/dose/route
Then call:
1. **911 (ask for advanced life support)**

2. Mother _____, Father _____, or emergency contacts.

3. Dr. _____ at _____
This child may/may not carry this medication. Name where; school, sports events, out of school address activities.

DO NOT HESITATE TO CALL 911!

_____ _____ _____ _____
Physician's Signature **Date** **Parent's signature** **Date**