

**Individualized Health Care Plan for Life-Threatening Allergies  
Including Food 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 with the allergen or I am having a reaction.

List any requires needed for food allergies.

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 exposed occurs. I will provide the medication with proper pharmacy label and be aware of the expiration date to replace the medication.

I hereby request that treatment 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 Diocese 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 Diocese 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)  
Extended Day Coordinator \_\_\_\_\_  
Coach \_\_\_\_\_ 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\* "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 ◆

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 \_\_\_\_\_

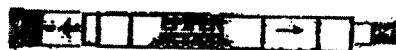
This child may/may not carry this medication. Name where; school, sports events, out of school activities. DO NOT HESITATE TO CALL 911!

Physician's Signature Date Parent's signature Date

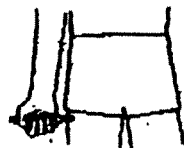
EMERGENCY CONTACTS		TRAINED STAFF MEMBERS	
1.	Relation: _____ Phone: _____	1.	_____ Room _____
2.	Relation: _____ Phone: _____	2.	_____ Room _____
3.	Relation: _____ Phone: _____	3.	_____ Room _____

**EPIPEN® AND EPIPEN® JR. DIRECTIONS**

- 1. Pull off gray safety cap**



- 2. Place black tip on outer thigh (always apply to thigh)**



- 3. Using a quick motion, press hard into thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and discarded. Massage the injection area for 10 seconds.**

Source: Food Allergy & Anaphylaxis Network. (2001)  
<http://www.foodallergy.org/school.html>

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Parent Signature \_\_\_\_\_ Date \_\_\_\_\_ This "Emergency Allergy Medication Permission Form" may be given to appropriate Teachers, Substitute teachers and Staff.