

MAYNARD

PUBLIC SCHOOLS

INDIVIDUALIZED HEALTHCARE PLAN SEVERE ALLERGY

To Be Completed By Parent

ID Photo

SCHOOL YEAR _____

STUDENT _____ BIRTH DATE _____ TEACHER _____

MOTHER _____ PHONE/DAY _____ OTHER # _____

FATHER _____ PHONE/DAY _____ OTHER # _____

MD/NP/PA _____ PHONE _____

CAUSE/SOURCE OF ALLERGY (Insect, Food, Other): _____

Please list any additional or hidden sources of the allergen (for example, peanut oil) on reverse side of this form.

PREVENTION/RESTRICTIONS/MODIFICATIONS: _____

Avoid Ingestion Avoid Direct Skin Contact Other _____

TYPICAL SIGNS/SYMPTOMS:

Swelling Coughing or sneezing Difficulty breathing Difficulty swallowing
 Itching or hives Stomachache, cramps, nausea, or vomiting Other _____

EMERGENCY CARE – If exposed to allergy source AND having symptoms noted above:

Administer EpiPen – dose: _____; Call 911 for transport to nearest ER (required)

Administer Benadryl – dose: _____

If exposed to allergy source but symptoms **do not** appear, then _____

Other _____

INSTRUCTIONS:

- If school is unable to reach parents in an emergency, permission is granted to contact medical provider and/or arrange transport to emergency services.
- Permission granted to photograph student or use school photo and include photo on this form.
- I/we agree to release this information to the following staff, as appropriate, with the expectation that appropriate confidentiality will be respected at all times.

- | | | |
|--------------------------------------------|--------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Academic Teachers | <input type="checkbox"/> Administrators | <input type="checkbox"/> Art, Music, Library, PE Teachers |
| <input type="checkbox"/> Recess Staff | <input type="checkbox"/> Kitchen/Cafeteria Staff | <input type="checkbox"/> Substitute Teachers |
| <input type="checkbox"/> Counselor | <input type="checkbox"/> Bus Personnel | <input type="checkbox"/> Other _____ |

Parent Signature

Date

Nurse Signature

Date