KIRKWOOD SCHOOL DISTRICT
INDIVIDUAL HEALTH PLAN (IHP) - SEVERE ALLERGIES

Name:	Date:
Birth Date:	Student #:
School:	Grade:
Asthmatic? Yes ☐ No ☐	Teacher:
Severe Allergy to:	**Section 504:** Has the student been declared eligible for Section 504? Yes ____ No____ If yes, list 504 eligibility date_____.

Allergy Symptoms:

MOUTH	Itching, tingling, or swelling of the lips, tongue, or mouth
SKIN	Hives, itchy rash, and/or swelling about the face or extremities
THROAT	Sense of tightness in the throat, hoarseness, and hacking cough
GUT	Nausea, stomach ache/abdominal cramps, vomiting, and/or diarrhea
LUNG	Shortness of breath, repetitive coughing, an/or wheezing
HEART	"Thready" pulse, "passing out," fainting, blueness, pale
GENERAL	Panic, sudden fatigue, chills, fear of impending doom
OTHER	Some students may experience symptoms other than those listed above

ACTION PLAN – To be completed by a physician or Licensed Health Care Provider

*****GIVE MEDICATION AS ORDERED ABOVE. AN ADULT IS TO STAY WITH STUDENT AT ALL TIMES*****

- Note time _____ AM/PM (Epinephrine given) Note time_____AM/PM (Antihistamine given)
- CALL 911 IMMEDIATELY. 911 must be called WHENEVER Epinephrine is administered.
- DO NOT HESITATE to administer Epinephrine and to call 911, even if the parents cannot be reached.
- Advise 911 that student is having a severe allergic reaction and Epinephrine is being administered.
- An adult trained in CPR is to stay with student to monitor and begin CPR if necessary.
- Call the School Nurse at _____.
- Student to remain with a CPR trained staff member at location where symptoms began until EMS arrives.
- Notify the administrator and parent/guardian.
- Dispose of used auto-injector in "sharps" container or give to EMS along with a copy of the IHP.

MEDICATION ORDERS

EpiPen (0.3mg) ☐ EpiPen (0.15mg) ☐ Antihistamine: Dose _____Medication_____

Repeat dose of EpiPen: Yes ☐ No ☐ If YES, when_____

Is it medically necessary for this student to carry an EpiPen during school hours? Yes ☐ NO ☐

Student may self-administer EpiPen. Yes ☐ No ☐

Student has demonstrated use to LHCP. Yes ☐ No ☐

Physician or Licensed Health Care Provider's Signature: _____

Physician or Licensed Health Care Provider's Printed Name _____

Date:_____ Fax:_____

Emergency Contact Numbers

Parent/Guardian 1) 2)	Home phone: Work: Cell: Work: Cell:
Emergency contact: Relationship:	Phone:
Primary Care Physician:	Phone:
School Nurse: Email:	Phone: Fax:

To be completed by school nurse with input from parent/guardian.

Bus Transportation (Bus driver should be alerted to student's allergy)

1) Does student carry Epinephrine on the bus? Yes_____ No_____
2) Epinephrine can be found in: Backpack_____ On person_____ Other:_____
3) Student will sit at front of bus: Yes_____ No_____
4) Other (specify)_____

Field Trip Procedures

1) EpiPen, antihistamine and Health Plan should accompany student during any off campus activity.
2) The student should remain with the teacher or parent/guardian during the entire field trip. Yes___ No___
3) Staff members on trip must be trained regarding auto-injector use and health care plan.
4) Other (specify)_____

Classroom - This student is allowed to eat only the following foods:

1) Packaged goods with ingredients listed and determined allergen free. Yes____ No____
2) Those approved by parent. Yes____ No____
3) Alternative snacks will be provided by parent/guardian to be kept in classroom. Yes____ No____
4) Classroom projects should be reviewed by teaching staff to avoid specific allergens. Yes____ No____
5) Student will sit at the classroom table at a specified location. Yes____ No____
6) Middle school or high school student will be making his/her own decision. Yes____ No____
7) Teachers, substitutes and specialists will be informed of Life Threatening Food Allergy. Yes____ No____
8) Other (specify)_____.

Cafeteria

1) Food service staff will be alerted to student's allergy. Yes____ No____
2) Health Care Plan will be made available to Food Service staff. Yes____ No____
3) NO RESTRICTIONS. Student can sit anywhere. Yes____ No____ (middle or KHS only)
4) Student will sit at a specified allergy table. Yes____ No____ (if student has Rx for epi-pen)
5) Specified table will be cleaned before and after lunch. Yes____ No____

Additional Health Information

Other Health Concern:	Other Health Concern:
Other Medications:	Dose/Time:
Dietary Concerns/Restrictions:	Dietary Concerns/Restrictions:

School Nurse Signature_____

Date_____

Parent Signature_____

Date_____