

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

<b>Name:</b>	Date:
Birth Date:	Student #:
School:	Grade:
Asthmatic?      Yes <input type="checkbox"/> No <input type="checkbox"/>	Teacher:
<b>Severe Allergy to:</b>	<b>Section 504:</b> 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	Home phone:
1)	Work: <span style="float: right;">Cell:</span>
2)	Work: <span style="float: right;">Cell:</span>
Emergency contact: Relationship:	Phone:
Primary Care Physician:	Phone:
School Nurse: Email:	Phone: Fax:
<b>To be completed by school nurse with input from parent/guardian.</b>	

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 \_\_\_

<b>Additional Health Information</b>
--------------------------------------

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

School Nurse Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_