MAYNARD

PUBLIC SCHOOLS

INDIVIDUALIZED HEALTHCARE PLAN
SEVERE ALLERGY

To Be Completed By Parent

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.

❑ Academic Teachers ❑ Administrators ❑ Art, Music, Library, PE Teachers

❑ Recess Staff ❑ Kitchen/Cafeteria Staff ❑ Substitute Teachers

❑ Counselor ❑ Bus Personnel ❑ Other _____

_____ _____

Parent Signature Date

_____ _____

Nurse Signature Date