

**St. Matthew School
Health Care Plan
Food Allergies**

Student's Name _____ Grade/teacher _____

Date of birth _____

Allergies _____

Circle typical signs and symptoms of your child's allergy: itching, swelling, hives, rash, nausea, abd cramps, vomiting, itching/swelling throat, hoarseness, cough, shortness of breath, wheezing, thready pulse, other _____

Current medications _____

Action Plan

List any school environmental measures that need to be implemented to decrease risk of reaction _____

Actions to be taken during an allergic reaction:

Medication, Dosage and Frequency to be given during allergic reaction

Medication delivered to school _____

Parent Contact _____

Will your child carry an epi pen? Yes or no, if yes, a back up epi pen must be in the school office.

MD contact in emergencies _____

School nurse will provide the following information to school staff

I give permission for my child to be given the above care

Parent signature _____

Date _____

MD signature _____

School nurse signature _____

Date _____