



Please attach additional pages as needed if space does not allow full information to be entered. Complete plan must still be printed, signed, and a hard copy returned to the school.

[ ]

Student Name [ ] Grade [ ] Teacher [ ]

Date of Birth [ ] Parents [ ]

Parent Contact Phones [ ]

M.D. [ ] Contact [ ] Hospital of Choice [ ]

SECTION 1: ALLERGIES

Please check here if your student has no allergies.

Please mark all that apply and provide appropriate information as requested.

Insect (Types [ ])  Food (Types [ ])  Seasonal ( [ ])
 Medication ( [ ])  Other ( [ ])

Please mark typical signs and symptoms of your child's allergic reactions:

Itching  Swelling  Hives  Rash  Nausea  Sneezing  Sinus drainage  Hoarseness
 Cough  Wheezing  Shortness of Breath  Thready Pulse  Cramps  Other [ ]

School environmental measures that need to be implemented to decrease risk of reaction

[ ]

ACTION STEPS TO BE TAKEN DURING AN ALLERGIC REACTION

[ ]

MEDICATION, DOSAGE, AND FREQUENCY TO BE GIVEN DURING AN ALLERGIC REACTION

[ ]

Will your child carry an epi pen?  Yes  No (If yes, a backup epi pen must be in the school office.)

(Office Use Only) Medication delivered to school on \_\_\_\_\_ Initials \_\_\_\_\_

SECTION 2: ASTHMA AND INHALERS

Please check here if these do not apply to your student.

Please mark all that apply and provide appropriate information as requested.

Asthma (Triggers: [ ]) (Environmental Concerns: [ ])
• Age of Diagnosis [ ] Date of Most Recent Asthmatic Episode [ ]

Non-Asthma Inhaler Use (Environmental Concerns [ ])

Restrictions to above: [ ]

Current Medications: [ ]

Please mark typical signs and symptoms that your child is experiencing difficulty with asthma and/or needs to use his/her inhaler:

Wheezing  Shortness of Breath  Cough  Blue or Gray Lips/Fingernails
 Other [ ]

MEDICATION, DOSAGE, AND FREQUENCY TO BE GIVEN BEFORE ACTIVITIES

[ ]

ACTION STEPS TO BE TAKEN DURING AN EPISODE

[ ]

MEDICATION, DOSAGE, AND FREQUENCY TO BE GIVEN DURING AN EPISODE

[ ]

Is your student permitted to self-administer his/her inhaler?  Yes  No PARENT INITIALS

If yes, the school office must have on file a signed note from the doctor stating the student understands when to use and not use the inhaler, and the student understands proper technique using the inhaler. Please attach a copy of the prescription order for the inhaler (pharmacy label on inhaler box will suffice). Parent and student understand that the inhaler is to be with the student during school hours—to all classes, PE, lunch, recess, Mass and all other activities. A backup inhaler must be in the school office.

*(Office Use Only) Medication delivered to school on* \_\_\_\_\_ *Initials* \_\_\_\_\_ *Dr. Note* \_\_\_\_\_ *Initials* \_\_\_\_\_

**Individual Health Plan (Continued)**

**2011-2012**

**Page 2**

Student Name  Grade  Teacher

**SECTION 3: FREQUENT HEADACHES**  *Please check here if this does not apply to your student.*

Student Condition/Diagnosis:

**ACTION STEPS TO BE TAKEN BEFORE/DURING AN EPISODE**

**MEDICATION, DOSAGE, AND FREQUENCY TO BE GIVEN DURING AN EPISODE**

*(Office Use Only) Medication delivered to school on* \_\_\_\_\_ *Initials* \_\_\_\_\_

**SECTION 4: SEIZURES**  *Please check here if this does not apply to your student.*

Student Condition/Diagnosis:

Seizure Triggers or Warning Signs:

**Seizure Protocol:** ● Stay calm and track time ● Keep child safe and remove any hazards ● Move other children from area  
● Do NOT restrain child or move child ● Do not put anything in mouth ● Protect head, assess airway/watch breathing  
● Notify parent or emergency contact ● Check  YES  NO to call 911 immediately ● Check  YES  NO to administer medication

**ACTION STEPS TO BE TAKEN DURING A SEIZURE**

**MEDICATION, DOSAGE, AND FREQUENCY TO BE GIVEN DURING A SEIZURE**

*(Office Use Only) Medication delivered to school on* \_\_\_\_\_ *Initials* \_\_\_\_\_ *Incident Report Filed* \_\_\_\_\_

**SECTION 5: ADDITIONAL HEALTH CONCERNS**  *Please check here if none.*

*Please provide any other health concerns of which school staff need to be aware for your child.*

STUDENT CONDITIONS:

**ACTION STEPS TO BE TAKEN DURING AN EPISODE**

**MEDICATION, DOSAGE, AND FREQUENCY**

*(Office Use Only) Medication delivered to school on* \_\_\_\_\_ *Initials* \_\_\_\_\_

**SECTION 6: MEDICATION CHECKLIST**  *Please check here if none.*

*Please list any medication that must or might be administered during the school day. Please re-enter information already listed above so the office has a quick checklist for your student. Please include dosage and frequency, including times of administration. Parents, please UPDATE this list by notifying school staff in writing of any changes throughout the school year.*

I understand that in the case of a serious medical emergency, unless the injury/illness appears to be immediately life-threatening, the staff will make reasonable attempts to contact me/us as specified above *before* authorizing medical treatment. If I/we are not available to give consent, I/we hereby authorize the staff of St. Matthew School to act on my/our behalf, to administer appropriate treatment, to call 911 emergency services, transport by ambulance, hospitalize; secure proper treatment; authorize injections, anesthesia, x-ray, surgery or other treatment for my child as deemed necessary by qualified medical personnel. I also understand that the medical information provided will be shared only on a medical "need-to-know" basis among staff and with treating medical personnel.

**Notice is hereby given** to qualified medical personnel that this authorization is currently in effect, and such personnel are directed to act upon this authorization without delay. I/we agree to assume financial responsibility for all expenses incurred in any emergency requiring medical attention.

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_