

# HEALTH CARE PLAN SEVERE ALLERGY TO:\_\_\_

Student Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_

School: \_\_\_\_\_

<b>Allergies</b> (food, insects, medication, etc): _____ _____	<b>Reaction:</b> _____ _____
<b>Diet Restrictions:</b> For food allergies: <input type="checkbox"/> parents will monitor school lunch menus or provide food and communicate with school personnel <input type="checkbox"/> student will self monitor food choices <input type="checkbox"/> teacher will assist child unable to self select food choices <input type="checkbox"/> other	

<b>Medications used on a daily basis</b> (include doses): HOME: _____ SCHOOL: _____
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**REMINDER: School personnel must take Epi-Pen® or any other medication on all field trips. Make sure phone is close by, if needed. Keep Epi-Pen® at room temperature. DO NOT FREEZE, refrigerate or keep in extreme heat.**

Pertinent Health History (as completed by School Nurse): \_\_\_\_\_

### EMERGENCY INFORMATION

Parent/Guardian	Number in order of preference	Number in order of preference
Home Phone:		
Cell Phone:		
Work Phone:		
Pager Number:		
Home Address:		
Emergency Contact:	<b>Name:</b>	<b>Phone:</b>
Emergency Contact:	<b>Name:</b>	<b>Phone:</b>

**Health Care Provider who should be called regarding the allergic reaction:**

<b>Name:</b> _____
<b>Phone:</b> _____
<b>Hospital Preference:</b> _____

If \_\_\_\_\_ experiences a change in health condition (such as a change in medication or hospitalization) please contact the School Nurse (RN) so that this Health Care Plan can be revised, if needed. Parent/guardian signature indicates permission to contact the child's health care provider(s) listed above, as needed. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure this child's safety and well being while at school or during school related activities.

Parent/Guardian Signature: (Required) \_\_\_\_\_ Date \_\_\_\_\_

School Nurse (RN) Signature: (Required) \_\_\_\_\_ Date \_\_\_\_\_

Administrator Signature: (Preferred) \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH CARE PLAN  
SEVERE ALLERGY TO: \_\_\_\_\_**

Student Name: \_\_\_\_\_  
Birthdate: \_\_\_\_\_

School: \_\_\_\_\_

**Emergency Treatment**

**If student experiences mild symptoms:**  
*several hives, itchy skin, itchy red watery eyes or nasal symptoms*  
**OR if an ingestion is suspected:**

**Treatment:**

1. Send student to health office **ACCOMPANIED.**
2. **Give \_\_\_\_\_ of \_\_\_\_\_ by mouth.**  
(amount and dosage: ) (antihistamine)
3. Contact the parent or emergency contact person.
4. **If exposed - Have child wash face, hands and exposed area.**
5. Stay with the student; keep student quiet, monitor symptoms, until parent arrives.  
**Watch student for more serious symptoms listed below.**

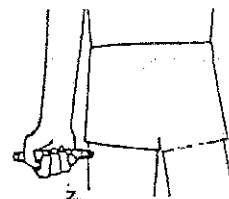
**Special Instructions:**

**Symptoms that progress and can cause a life threatening reaction:**

- *Hives spreading over the body.*
- *Wheezing, difficulty swallowing/ breathing, swelling (face, neck), tingling/swelling of tongue.*
- *Vomiting*
- *Signs of shock (extreme paleness/gray color, clammy skin, etc.), loss of consciousness.*

**Treatment:**

1. **Give:**  **Epi-Pen Jr.®** OR  **Epi-Pen®** immediately  
(under 66lbs) (66lbs & over)
- Place against upper outer thigh, through clothing if necessary.
2. **Call 911** (or local emergency response team) immediately.
  3. Epi-pen® only lasts 20-30 minutes.
  - \*\*Paramedics should always be called if Epi-Pen® is given\*\***
  4. Contact parents or emergency contact person. If parents unavailable, school personnel should accompany the child to the hospital.



**Directions for use of Epi Pen®:**

1. Pull off gray cap.
2. Place black tip against upper outer thigh.
3. Press hard into outer thigh, until it clicks.
4. Hold in place 10 seconds, and then remove.
5. Discard Epi Pen® in impermeable can and dispose per school policy, or give to emergency care responder. (Do not return to holder)

It is understood by parents and health care provider(s) that this plan may be carried out by school personnel other than the School Nurse Consultant (RN). A RN is to be responsible for delegation of this Health Care Plan to unlicensed persons.

Health Care Provider Authorization (Required): \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature (Required): \_\_\_\_\_

Date: \_\_\_\_\_

# Beaver Creek Day Camp

## PERMISSION TO ADMINISTER MEDICATION IN CHILD CARE (ONE FORM PER MEDICATION)

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*To be completed by the child's health care provider with prescriptive authority:*

Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route \_\_\_\_\_

Time of day medication is to be given: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Start date \_\_\_\_\_ End date \_\_\_\_\_

\_\_\_\_\_  
Signature of Person with Prescriptive Authority Phone # \_\_\_\_\_ Date \_\_\_\_\_

Print name:

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*To be completed by the parent or guardian*

I hereby give my permission for \_\_\_\_\_ to take the  
(Child's Name)  
above medication, in child care, as ordered by the health care provider. I understand that  
it is my responsibility to furnish this medication.

\_\_\_\_\_  
Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Note:** The medication is to be brought to child care in the original container which clearly states the child's name, the health care provider, the name of the medication, date, time and dosage. This form must also be filled out completely in order for the medication to be given. This is the Division of Child Care Licensing requirement .