HERNANDO COUNTY SCHOOL DISTRICT

ALLERGY CARE PLAN

School Year _____ - _____

Student Name_____ Date of Birth_____

School Name_____ Grade_____ Teacher_____ Bus_____

Contact Information:

Parent/Guardian #1_____ Phone#: Home_____ Work_____ Cell_____

Parent/Guardian #2_____ Phone#: Home_____ Work_____ Cell_____

Emergency Contact_____ Relationship_____ Phone#_____

Emergency Contact_____ Relationship_____ Phone#_____

Allergy Specialist_____ Phone#_____

Primary Physician_____ Phone#_____

Hospital Choice: <u>Please circle.</u>

Brooksville Regional Hospital Oak Hill Hospital Spring Hill Regional Hospital

Emergency Notification:
<u>Circle the symptoms</u> usually seen for this child (if parent/guardian(s) can't be located, 911 will be called for student in acute distress).

- Shortness of Breath/Difficulty Breathing
- Chest tightness
- Chest Pain
- Wheeze
- Dusky Color
- Lips/Nails Blue in Color
- Rash/Hives
- Straining Neck Muscles
- Itching
- Nasal Flaring (Widening)
- Vomiting
- Diarrhea
- Unable to Speak in Complete Sentences
- Hunched Shoulders

Other_____

Date of Last Allergic Reaction_____

Date of Last Hospitalization_____

Please complete second page.

Student Name_____

ALLERGY MEDICATIONS AT SCHOOL/HOME

Name_____ Dosage_____ Frequency_____

Name_____ Dosage_____ Frequency_____

Name_____ Dosage_____ Frequency_____

Rescue Treatment:

Name_____ Dosage_____ Frequency_____

DOES STUDENT HAVE CONTRACT TO CARRY EPI PEN? _____YES_____NO

Allergic To: Circle all that apply.

Food (list all/be specific)_____

Insects (be specific)_____

Medications_____

Latex Cats Dogs Mold Sprays Smoke

Environmental Allergies_____

Household Products_____

Seasonal Allergies_____

Other_____

List other emergency procedures for student experiencing allergic signs/symptoms

_____

_____

Parent/Guardian Signature and Date_____

Public Health Nurse Signature and Review Date_____