HERNANDO COUNTY SCHOOL DISTRICT

ALLERGY CARE PLAN

School	ol Year				
Student Name	ent Name Date of Birtl				
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 F	Regional Hospital		
Emergency Notification: Circle the symptoms usually seen for this child (if pare	nt/guardian(s) can't be	located, 911 will be called f	or 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	Dia	rrhea			
Unable to Speak in Complete Sentences	Hui	nched Shoulders			
Other					
Date of Last Allergic Reaction					
Date of Last Hospitalization	_				

Student Name			
SIGUELLINALIE			

ALLERGY MEDICATIONS AT SCHOOL/HOME

Name		Γ	Oosage		_ Frequency	
Name		Γ	osage		_ Frequency	
Name		Γ	Oosage		_ Frequency	
Rescue Treatment:						
Name		Γ	osage		_ Frequency	
DOES STUDENT I	HAVE CONTRACT TO C	CARRY EPI PEN	YES	NO		
Allergic To: Circle all	that apply.					
Food (list all/be specifi	c)					
Insects (be specific)						
Medications						
Latex Cat:	s Dogs	Mold	Sprays	Smoke		
Environmental Allergie	es					
Household Products_						
Seasonal Allergies						
Other_						
	procedures for student expe					
Daront/Guardian Signa	iture and Date					
ratent/ Guardian Signa	nure and Date					
Public Health Nurse Si	enature and Review Date					