LAKE COUNTRY SCHOOL DISTRICT – ALLERGIC REACTION INDIVIDUALIZED HEALTH PLAN

Student Name:	Home Phone Number:
Mother's Name:	Work Phone Number:
Father's Name:	Work Phone Number:
Physician:	Physician's Phone Number:

ALLERGIC TO: ____

Please check your child's typical allergic reaction symptoms….

____ difficulty breathing or wheezing
____ violent abdominal pain
____ swelling of face throat or tongue
____ change in voice quality
____ collapse
____ hive like skin reaction or swelling
____ seizure
____ other

Treatment Plan:

1. Call the school nurse
2. Call 911 to transport to Waukesha or Oconomowoc Hospital for severe allergic reaction.
3. Give injection of: _____ EPI-Pen 0.3 mg Epinephrine
   _____ EPI-Pen Jr. 0.15 mg Epinephrine
   Physician is to indicate dose. Injection is to be self administered by student or school nurse. No school employee, except a health care professional is required to administer any drug to a pupil by means other than ingestion. WI ACT 334
4. Administer any additional medications physician ordered below.
5. Administer CPR if necessary.

Parental Consent:

- I hereby give my permission for the school nurse, health room personnel, office staff or authorized school personnel to give the medication to my child according to the directions stated below.
- I give permission to the school nurse to contact the student's physician.
- I further agree to hold the Lake Country School District, and the above-identified person(s), harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.
- I agree to notify the health room at the termination of this request or when changes in the below orders is necessary.
- If I cannot be reached by phone and my child does not respond to the medication listed below, 911 will be called to transport my child to the nearest hospital.

________________________ ____

Date Signature or Parent/Legal Guardian

TO BE COMPLETED BY A PHYSICIAN

For School Year ________________

➡ **Epinephrine:** ____ 0.3 mg IM **OR** ____0.15 mg IM ____May repeat dose in 15 min.

➡ **Middle School or High School ONLY: Student may self-carry medications:** ____

➡ **Antihistamine:** ____

➡ **Other Medication(s):** ____

EPI-Pen – May student self-administer and keep the EPI-Pen under their control in such place as their backpack, purse or pockets? _____YES _____ NO

________________________ ____

Date Physician Signature

WASB Code: 453.4 Adopted by School Board: April 21, 2015