# MAYNARD PUBLIC SCHOOLS

## INDIVIDUALIZED HEALTHCARE PLAN
## SEVERE ALLERGY

*To Be Completed By Parent*

ID Photo

**SCHOOL YEAR** _______________

**STUDENT** ______________________________ **BIRTH DATE**__________ **TEACHER**____________

**MOTHER** ______________________________ **PHONE/DAY** ___________ **OTHER #** ___________

**FATHER** ______________________________ **PHONE/DAY** ___________ **OTHER #** ___________

**MD/NP/PA** ______________________________ **PHONE** __________________________

**CAUSE/SOURCE OF ALLERGY** (Insect, Food, Other): ______________________________________

Please list any additional or hidden sources of the allergen (for example, peanut oil) on reverse side of this form.

**PREVENTION/RESTRICTIONS/MODIFICATIONS**: ______________________________________

- ❑ Avoid Ingestion
- ❑ Avoid Direct Skin Contact
- ❑ Other ______________________________

**TYPICAL SIGNS/SYMPTOMS**:

- ❑ Swelling
- ❑ Coughing or sneezing
- ❑ Difficulty breathing
- ❑ Difficulty swallowing
- ❑ Itching or hives
- ❑ Stomachache, cramps, nausea, or vomiting
- ❑ Other _____________

**EMERGENCY CARE – If exposed to allergy source AND having symptoms noted above:**

❑ Administer EpiPen – dose: ______________________; Call 911 for transport to nearest ER (required)

If exposed to allergy source but symptoms **do not** appear, then ________________________________

______________________________________________________________________

**INSTRUCTIONS**:

- ❑ If school is unable to reach parents in an emergency, permission is granted to contact medical provider and/or arrange transport to emergency services.
- ❑ Permission granted to photograph student or use school photo and include photo on this form.
- ❑ I/we agree to release this information to the following staff, as appropriate, with the expectation that appropriate confidentiality will be respected at all times.

  - ❑ Academic Teachers
  - ❑ Administrators
  - ❑ Art, Music, Library, PE Teachers
  - ❑ Recess Staff
  - ❑ Kitchen/Cafeteria Staff
  - ❑ Substitute Teachers
  - ❑ Counselor
  - ❑ Bus Personnel
  - ❑ Other _______________

______________________________________ ________________

Parent Signature Date

______________________________________ ________________

Nurse Signature Date