## MISSISSINEWA COMMUNITY SCHOOLS HEALTH SERVICES

Northview Elementary ~ Ph: (765) 677-4400 Fax: (765) 677-4733 Westview Elementary ~ Ph:(765) 677-4437 Fax: (765) 677-4449

RJ Baskett Middle School ~ Ph: (765) 674-8536 Fax: (765) 677-4452 Mississinewa High School ~ Ph: (765) 674-2248 Fax: (765) 677-4424

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

## **PLAN OF CARE ~ ALLERGIES**

Name:Parent/Guardian Name:		Date of Birth:		Grade:		
		Home Ph. #:	Work Ph. #:			
Emergency Contact #	‡1: Name					
			Home Ph. #	Work/Cell Ph. #		
Emergency Contact #	#1: Name	Relationship	Home Ph. #	Work/Cell Ph. #		
Asthma: Yes		, , , , , , , , , , , , , , , , , , , ,				
Systems: • MOUTH	AN ALLERGIC REASING Symptoms: itching & swelling of lips, to					
• THROAT*	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough					
• SKIN	hives, itchy rash, and/or swelling					
• GUT	nausea, abdominal cramps, vomiting, and/or diarrhea					
LUNG*	shortness of breath, repetitive coughing, and/or wheezing					
• HEART* The severity of symp	"thready" pulse, "passing-outoms can quickly change. *All a	ut" bove symptoms can potentially prog	ress to a life-threate	ning situation.		
■ ACTION FO	OR MINOR REACTI	ION ►				
Symptom(s)	are:					
	age): ot improve within 10 MINU	ITES, follow steps for MAJOR	REACTION below	<b>w</b> .		
<b>▲</b> ACTION FO	R MAJOR REACT	ION ▶				
Symptom(s)	are:					
Do/Give (dos	age):					
		ired in the past year for allerg		es No		
· · ·						

		Yes	No	
Administer Epi-Pen if the	e following sym	iptoms are observed	:	
If Epi-Pen is required:				
Please Check One:				
Administe	r <b>before</b> sympt	oms occur & immedi	ately upon expo	sure.
Administe	r <i>if</i> symptoms o	occur.		
Epi-Pen Auto Inje	ector Dosage:	Adult 0.3 mg Junior 0.15 mg	Yes _ Yes _	No No
Please Check One:				
and <b>may</b> o	carry their own	pharmacy labeled E	pi-Pen at all time	
Physician's Printed I	Name	Physician's Signature		
Phone Number		Fax Number		Date
Phone Number	*****		******	Date
************		********	Epi-Pen	Date
**************************************	Parental (	Consent for	-	********
**************************************	Parental (	Consent for	Epi-Pen	*********
the parent or guardian of the nd School Bus Drivers of Miss ccording to the manufacturer's understand that if the Epi-Pen	above named sissinewa Comis instructions a	Grade: student, authorize pramunity Schools Corpand physician's orders	School Sc	ol:  nd oriented Staff Member hister my child's Epi-Pen
Student Name:  the parent or guardian of the and School Bus Drivers of Missiscording to the manufacturer's understand that if the Epi-Pen	above named sissinewa Comis instructions a	Grade: student, authorize pramunity Schools Corpand physician's orders	School Sc	ol:  nd oriented Staff Member hister my child's Epi-Pen
the parent or guardian of the nd School Bus Drivers of Miss coording to the manufacturer's understand that if the Epi-Pen ffectiveness of the Epi-Pen. Turther understand that every	above named sissinewa Comis instructions and is administere. The school nurs attempt shall b	Grade: student, authorize pramunity Schools Corpand physician's orders ed, 911 will be called se and an administra	School Sc	ol:  nd oriented Staff Member ister my child's Epi-Pen ll be asked to evaluate the otified.
************	above named sissinewa Comis instructions and is administere. The school nurs attempt shall b	Grade: student, authorize pramunity Schools Corpand physician's orders ed, 911 will be called se and an administra	School Sc	ol:  nd oriented Staff Membernister my child's Epi-Pen  Il be asked to evaluate the otified.