Grand Haven Area Public Schools

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Place Child's Picture here

School Life-Threatening Allergy Individual Health Plan

Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

TO BE COMPLETED BY PARENT/GUARDIAN

I, the parent/guardian of:_____birth date of:_____request that the building administrator, or his/her designee, administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I fully realize I can withdraw my request/consent in writing at any future date.

As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy.
2. To provide the school with the written doctor's instructions for medication administration during school hours.
3. To inform the school of any medical changes.
4. To provide the school with this signed consent form annually and when changes in medication occur.

Parent/Guardian Signature:_____Phone:_____ Date:_____

Allergic to:_____ _____

Allergy Symptoms Specific to Student: _____

Medications to be given at school:

Name of Medication	Dosage	When To Use

Medications Taken At Home Include:

Name of Medication	Dosage and Time

Signs and Symptoms of an Allergic Reaction	
Itching and swelling of the lips, tongue, or mouth	Itching and/or a sense of tightness in the throat, hoarseness, and a hacking cough
Hives, itchy rash, and/or swelling about the face or extremities	Nausea, abdominal cramps, vomiting and/or diarrhea
Shortness of breath, repetitive coughing and/or wheezing	"Thready" pulse, or passing out

The Severity of Symptoms Can Change Quickly and Progress to a Life-Threatening Situation.

If symptoms are severe:

Call 9-1-1 **Locate and administer Epi-Pen if indicated above** **Notify Parents**

- I have instructed this child in the proper way to use his/her epinephrine auto-injector. Please check the answer that best applies:
  - ☐ It is my professional opinion that this child ***should be allowed to carry and use*** this medication by him/herself.
  - ☐ It is my professional opinion that this ***should not carry*** his/her auto-injector by him/herself.

Physician Printed Name & Signature _____ Date _____

This also authorizes an exchange of information, as necessary, between the school and my child's health provider. This form is to be kept in the student's CA-60 school records. This form is to be reviewed annually or whenever the prescription changes during the current school year. *Rev. 09/07*