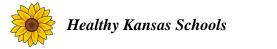


NOTE: Parents are to provide the physician's medical management plan to the school *annually*. The medical orders, along with the health intake below, assist the school nurse in developing an Individual Healthcare Plan for the student.

Student's Name:	DOB:/	/	_Grade:	Today's Date://							
Parent/Guardian 1:	Contact Information:										
Parent/Guardian 2:	Contact Information:										
Name of physician treating student's allergies	:			Phone Number:							
Health Insurance:	□ Medicaid/KanCare		re	\Box Currently without insurance							
Medical alert jewelry worn? □ Yes □ No	IEP? □]Yes □	No	Current 504 Plan? □ Yes □ No							
Mode of transportation to and from school?											
Does student participate in before or after school activities? Ves No											
Does student have a diagnosis of severe allergy from a healthcare provider? Des Yes Does No											
Student is allergic to (check all that apply):											
□ Peanuts □ Tree Nuts □ Eggs □ Milk □ Fish □ Shellfish □ Soy □ Wheat □ Bee Stings □ Latex											
□ Other:											
Describe student's first allergic reaction:											
Age or date:											
Symptoms:											
Allergen (if known):											
How quickly symptoms appeared after exposure:											
Severity (including need for hospitalization):											
Describe student's most recent allergic reaction:											
Age or date:											
Symptoms:											
Allergen (if known):											
How quickly symptoms appeared after exposure:											
Severity (including need for hospitalization)	:										
Has an epinephrine injection (such as EpiPen) been given for a past allergic reaction? Yes No											
If yes, how many times has epinephrine been administered?											
More about student's symptoms:											
What are student's early signs and symptoms of an allergic reaction?											
How does student communicate symptoms?											



What might student say during a reaction?

Ple	ease check a	<u>ll</u> symptoms that	at student has e	xperienced in th	ne past:							
	- Skin:	☐ Hives	□ Itching	□ Rash	☐ Flushing	□ Swelling	(face, arms, hands, legs)					
	Mouth:	□ Itching	□ Swelling (lip	os, tongue, mout								
	Abdominal	: 🗆 Nausea	\Box Cramps \Box Vomiting		□ Diarrhea							
	Throat:	□ Itching	□ Tightness	□ Hoarseness	□ Cough							
	Lungs:	\Box Shortness of breath \Box Repetitive		□ Repetitive c	ough	□ Wheezing						
	Heart:	<i>rt:</i> \Box Weak pulse \Box Loss of consciousness										
Sti	Student self-care (Please indicate student's skill level for the following):											
	Knows what foods to avoid			□ Yes	□ No							
	Asks about food ingredients			□ Yes	□ No	NOTE: Self-care at school will be determined in consideration of the above information, healthcare provider orders, and school nurse ongoing assessment of student's skills.						
	Reads and understands food labels Tells an adult immediately after an exposure Tells peers and adults about the allergy Firmly refuses a problem food Knows how to use emergency medication				□ Yes		□ No					
					□ Yes		□ No					
					□ Yes		□ No					
					□ Yes		□ No					
					□ Yes		□ No					
	Has administered emergency medication to self in the past			□ Yes	□ No							
M	eal plan:											
Will student participate in breakfast at school?												
	Will student bring lunch, eat school lunch, or both?											
	Does student regularly eat snacks at school?											
Cl	assroom sna	acks/birthday tr	eats from other	students: We re	ecommend that p	oarents/guard	ians provide a supply of					
individualized snacks for early childhood and younger elementary-age students with known food allergies. Please indicate												
yo	ur preference	e by <i>selecting <u>on</u></i>	<u>e</u> of the followin	ng:								
I will provide <i>all</i> of my student's food. He/she is not to eat other snacks/treats at school unless I am												
pre	esent or have	provided prior	written approval	specific to the i	tem.							
		_ My student kn	ows about foods	to avoid and ma	ay eat snacks/tre	ats provided	by others.					
Do	es student l	nave family, pee	r, and commun	ity support syst	ems? 🗆 Yes 🗆 🗄	No						
De	scribe stude	ent's response a	nd current copi	ing/adaptation t	o having severe	allergies: _						
Pa	rent/Guard	ian Signature: _				Date: _						