

**CARE PLAN FOR A STUDENT WITH ANAPHYLACTIC ALLERGY**

NORRIS PUBLIC SCHOOLS  
25211 S. 68<sup>TH</sup> STREET  
FIRTH, NE 68358

THIS PLAN IS FOR THE  
SCHOOL YEAR FROM  
\_\_\_\_\_ TO  
\_\_\_\_\_.

**Your Child's Name :** \_\_\_\_\_ **CURRENT GRADE IN SCHOOL** \_\_\_\_\_

**Mother's Phone Number:** Home) \_\_\_\_\_ Work) \_\_\_\_\_ Cell ) \_\_\_\_\_

**Father's Phone Number:** Home) \_\_\_\_\_ Work) \_\_\_\_\_ Cell ) \_\_\_\_\_

Physician Providing Allergy Care: \_\_\_\_\_ Phone: \_\_\_\_\_

**DESCRIPTION OF ALLERGY**    **This child is allergic to:** \_\_\_\_\_

What have allergy symptoms been in the past? \_\_\_\_\_

Sensitivity to allergen has been \_\_\_\_\_ by eating    \_\_\_\_\_ by skin contact    \_\_\_\_\_ air borne    \_\_\_\_\_ sting/injection

If a food allergy, can your child identify foods to avoid? \_\_\_\_\_

For allergy other than food (insect, latex, etc.), can your child identify situations/objects to avoid? \_\_\_\_\_

What adjustments have you made at home and out in public? \_\_\_\_\_

**PREVENTATIVE MEASURES AT SCHOOL WILL INCLUDE:** (Completed by parent/guardian together with Norris staff members)

1) \_\_\_\_\_

\_\_\_\_\_

2) \_\_\_\_\_

\_\_\_\_\_

3) \_\_\_\_\_

\_\_\_\_\_

4) \_\_\_\_\_

\_\_\_\_\_

5) \_\_\_\_\_

\_\_\_\_\_

**RESPONSE PLAN FOR AN ALLERGIC REACTION:**

- 1) Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ for the following symptoms: \_\_\_\_\_.
- 2) Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ for the following symptoms: \_\_\_\_\_.
- 3) Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ for the following symptoms: \_\_\_\_\_.

**Call 911 for the following symptoms:** \_\_\_\_\_  
\_\_\_\_\_.

**Contact parent/guardian as soon as possible and identify possible source of allergen.**

**Does your child have permission to carry and self-provide any of these medications? If so, which medications?** \_\_\_\_\_

STAFF SIGNATURE \_\_\_\_\_ POSITION \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_

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STAFF SIGNATURE \_\_\_\_\_ POSITION \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_

**PHYSICIAN'S REQUEST FOR PROVISION OF PRESCRIPTION MEDICATION AT SCHOOL**

NORRIS SCHOOL DISTRICT #160, 25211 S. 68<sup>TH</sup> St., Firth, NE 68358

The student, whose name is: \_\_\_\_\_, is under my care for the following condition: SEVERE ALLERGY TO : \_\_\_\_\_ and must take medication which I have prescribed for an allergic reaction.

My prescription for medications in response to an allergic reaction at school or school events is as follows (Please include medication name, dose, route, and frequency at school):

The duration of this medication therapy is: \_\_\_\_\_ for the current school year.  
\_\_\_\_\_ for this time: (\_\_\_\_\_)

Any other instructions:

This student will be able to self-provide this medication. The parent/guardians, student, and I have discussed how to use this medication correctly, store the medication, and report the effects of the medication to me and to the school.  
If applicable, I also authorize the use of syringes or similar medical items.

This student cannot self-provide this medication. I, or my designee, have trained school personnel or approved alternative training as adequate to provide this medication. The plan for administration is appropriate and safe. As applicable, syringes an other similar medical items can be used.

\_\_\_\_\_  
PHYSICIAN OR PRESCRIBER'S SIGNATURE

\_\_\_\_\_  
DATE

CLINIC NAME OR STAMP: