

**McKinney Independent School District
School Health Services**

Attach
Photo

Individualized Health Plan, Life Threatening Allergy

Reviewed & accepted as IHP for current school year only. RN signature/date _____

Student's Name: _____ Date of Birth: _____ ID _____

Grade: _____ Homeroom Teacher: _____ Date of diagnosis: _____

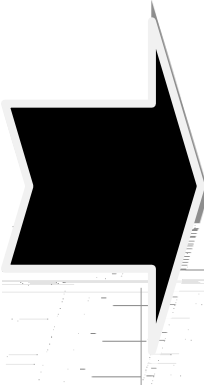
Severe Allergy to: _____ **Has your child ever had a reaction?** Yes No

What was/were signs and symptoms of the reaction? _____

Asthmatic: Yes No **** Higher risk for severe reaction**** Medication expiration date(s): _____

Lung: Shortness of breath, repetitive coughing, wheezing
 Heart: Thready pulse, low blood pressure, fainting, pale, blueness
 Throat: Tightening of throat, hoarseness, hacking cough
 Mouth: Itching, tingling or swelling of lips, tongue, mouth
 Skin: Many hives all over the body

Skin: Hives, itchy rashes, swelling
 Gut: Vomiting, crampy pain



--Call 911
 --Begin Monitoring (see below)
 --Additional medications
 ** Antihistamine
 ** Inhaler (bronchodilator) if Asthma

***Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis)*

***When in doubt, use Epinephrine. Symptoms can rapidly become more severe*



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Student s Name: _____ ID _____

After EMS notified

--Gather accurate information about the reaction, including medical intervention and
who witnessed the reaction. (10 pts)

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Student's Name: _____ ID _____

Student/Family Goals for this School Year:

Student will increase self-management as evidenc

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**Health Condition Information Sheet
(HEALTH SERVICES USE ONLY)**

Student's Name _____ D.O.B. _____
Condition _____ Grade _____
Physician's Name _____ Phone # _____
Parent's Name(s) _____ Home Phone # _____
Street Address _____ Work Phone # _____
Employer _____ Cell/Mobile # _____

Emergency Contact #1 _____ Phone # _____
Emergency Contact #2 _____ Phone # _____

If signs or symptoms of the above condition are noted please take the following steps:

- A) If this happens: _____
Then do this: _____
- B) If this happens: _____
Then do this: _____
- C) If this happens: _____
Then do this: _____

Please circle one of the following to indicate the level at which this student can perform this care.

Independently Needs Assistance/Supervision Cannot do for self

Additional Comments: _____

School RN's Printed Name: _____ Signature: _____ Date: _____
Optional Parent Printed Name: _____ Signature: _____ Date: _____
Optional MD Printed Name: _____ Signature: _____ Date: _____