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 witne

6 J002 Trew* h0 Tdts)
BDC q1 0 0 1 72 95.2 cm0.567 w 1 j 0 J 0 0 m135.05 0 lSQi

_____ _____ _____ _____

McKinney Independent School District
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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: _____