St. Matthew's
CHURCH AND SCHOOL

SEVERE ALLERGY (EPI-PEN NEEDED)
HEALTH ACCOMMODATION PLAN
(Not to be used for Bee, Food or Latex Allergy)
District Nurse Phone: 262-560-2104
District Nurse Fax: 262-560-2106

Name	_____	School Year	_____
Birthdate	_____	School	_____
Practitioner	_____	Grade	_____
Practitioner Phone	_____	Practitioner Fax	_____

ALLERGY TO:____ _____

☐ **Severe Allergies are no longer an issue for my child. (Please sign and return Care Plan)**

Symptoms:	**Give Checked Medication**:** **(To be determined by practitioner authorizing treatment)	
• Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐Epinephrine	☐Antihistamine
• Skin Hives, itchy rash, swelling of the face or extremities	☐Epinephrine	☐Antihistamine
• Gut Nausea, abdominal cramps, vomiting, diarrhea	☐Epinephrine	☐Antihistamine
• Throat† Tightening of throat, hoarseness, hacking cough	☐Epinephrine	☐Antihistamine
• Lung† Shortness of breath, repetitive coughing, wheezing	☐Epinephrine	☐Antihistamine
• Heart† Thready pulse, low blood pressure, fainting, pale, blueness	☐Epinephrine	☐Antihistamine
• Other†_____	☐Epinephrine	☐Antihistamine
• If reaction is progressing (several of the above areas affected), give	☐Epinephrine	☐Antihistamine

****The severity of symptoms can quickly change and progress to a life-threatening situation****

Administer per instructions above:

☐ Give Antihistamine: Medication Name:_____ Dose:_____Call Parent.

☐ Give injection of:

☐ No Epinephrine ☐ Epinephrine Dose: ☐ 0.3 mg ☐ 0.15 mg
☒ Per State Statute, 911 will be called any time Epinephrine is administered.

******Please supply the school with the needed medication prior to the first day of school******

☐ It is my professional opinion that this student **should** be allowed to carry the Epi-pen.

Where will Epi-pen be kept _____

☐ It is my professional opinion that this student **should not** carry his/her Epi-pen medication.

_____
Practitioner Signature **Date**

How should medications be returned home at the end of the year? ☐**Sent home with Student** ☐**Parent/Guardian Pick-Up**

- I hereby give permission to St. Matthew's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's practitioner with any concerns regarding medication administration. I agree to hold St. Matthew's School, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

_____
Parent/Guardian Signature **Date**