The International School
Health Care Action Plan
School Year: 2017 - 2018

STUDENT INFORMATION:

Name: _____

Date of Birth: _____ Grade (in 2017-2018): _____

Identified/Allergen(s):

_____

Other Relevant Health Concerns:

_____

CONTACT INFORMATION

Parent 1: Name- _____ Phone-_____

Parent 2: Name- _____ Phone-_____

Emerg. Contact: Name- _____ Phone-_____

Healthcare Provider's Name- _____ Phone-_____

Preferred Hospital- _____

HEALTH HISTORY

At what age was the student diagnosed with a health condition or allergy?:

_____

What are the student's usual symptoms in an allergic reaction or health condition?:_____

If child has allergies; approximately how many allergic reactions has the student experienced?:_____

When was his/her last allergic reaction?: _____

Has the student been hospitalized as a result of an allergic reaction?

☐ yes How many times? _____ ☐ no

Has the student experienced an allergic reaction at school before?

☐ yes How many times? _____ ☐ no

Is there anything else that the school should know regarding your child's allergy or health history?

PLEASE CONTINUE ON THE OTHER SIDE

TREATMENT

***** An allergic reaction may include any or all of these symptoms:**

General- *dizziness, loss of consciousness, feeling of panic or doom*
Mouth- *swelling of lips, face, tongue, throat; a report that the mouth "feels hot"*
Breathing- *wheezing, difficulty breathing, congested, cough, tightness of throat*
Stomach- *discomfort, nausea, vomiting, abdominal cramps, diarrhea*
Skin- *hives, swelling, rash*

When you see any of the above symptoms, it is important to initiate the following plan of care:

Please List the care/medications to be given if the above symptoms arise: (this can include giving Claritin, Benadryl, Epinephrine)

1._____ Dosage_____

2._____ Dosage_____

3._____ Dosage_____

_____ Dosage_____

(*911 will always be called if epinephrine is administered*)

Other Directions for care of symptoms:

_____

_____

_____

The International School staff has my permission to assist and/or administer over the counter medication to my child, _____, according to the opinion of the staff, as needed.

Yes (Check)	No (Check)	(please circle if necessary)	Medication (generic name)	Dose (please specify)	Or (please circle)
		Call parent first	Tylenol, (Acetaminophen)		as recommended for age
		Call parent first	Motrin, Advil, (Ibuprofen)		as recommended for age
		Call parent first	Claritin, (Loratadine)		as recommended for age
		Call parent first	Benedryl, (Diphenhydramine)		as recommended for age
		Call parent first	Tums, (calcium carbonate antacid)		as recommended for age
		Call parent first	Pepto Bysmol (bismuth subsalicylate)		as recommended for age
		Call parent first	Hydrocortizone cream		as recommended for age

Emergency Plan written by: _____ Date: _____

The parent/guardian signature authorizes the school to share this information with school staff on a "need-to-know" basis. In the event of an emergency, care will be initiated and parents will be contacted. This plan is in effect for the current school year as needed only.

Parent/Guardian Signature: _____ Phone:_____

Healthcare Provider's Signature: _____ Date: _____

If you have additional medical documents that you would like to share regarding your child's allergy or the procedure for treating an allergic reaction, please attach them to this form. **Please deliver these forms to the Stearns Hall or Hilltop receptionists.**

To be filled out by the front office staff: Location and # of child's Epi-pens, Benadryl, or other medication-