Hollidaysburg Area School District
ALLERGY CARE PLAN

Student's Name: ______________________________Grade: _____School Year: _______________

Goal #1: Student will not experience any allergy reaction at school/school activity during the current school year by avoiding contact with the allergen.
Goal #2: If the student does experience an allergy reaction at school, the episode will be controlled by the outlined care plan to prevent further medical complications or emergency medical care.

In Case of emergency, contact:

1. **_____________________________Phone _____________ Relationship: _______________**
2. **_____________________________Phone _____________ Relationship: _______________**

Allergy To: ____

Please Indicate your child's reaction:

____ Rash/Hives
____ Mouth/Throat (tightening, swelling)
____Respiratory (shortness of breath, coughing, wheezing)
____Cardiac (fainting, pale)
____No Reaction
____Other, Please indicate: ____
____

Medication:

____ None Required
____Yes, Medication Prescribed: ____
****If medication required, the physician must complete the attached medication form for school ****

Steps to be taken if contact occurs:

____
____
____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

*****School staff have been instructed on the use of Epipens and Inhalers and will be able to assist the child in an emergency situation. Other medication must be given by a licensed school nurse only.**

Parent Signature: ____ Date: ___________________

Physician Signature: ____Date: ___________________

REV/10-18def