INDIVIDUAL HEALTH CARE PLAN
EPI-PEN® ADMINISTRATION
Lawrence Extended Day Program

Date_____

Dear Parent/Guardian: The following is an emergency health care plan for your child, who has been noted to have an allergy which could require treatment in school with an EpiPen®. Please complete the parent/guardian section and forward this form to your child's physician. Please request that this form be returned to the LEDP right away. Thank you. Sincerely,

_____ Phone #_____
Lawrence Extended Day Program

TO BE COMPLETED BY PARENT/GUARDIAN

PHOTO

Student's Name_____Gr/Class_____
Asthma: ___Yes ___No School_____

Allergy to_____
_____

Signs and Symptoms of Previous Allergic Reactions:_____
_____

Permission to administer / self administer medications as prescribed _____ _____
(circle appropriate choice) (Parent/Guardian Signature) (Date)

Parent/ Guardian Information:
Name_____ Home #_____
Work #_____Cell Phone #_____

Name_____ Home #_____
Work #_____Cell Phone #_____

Other Emergency Contact Information:
Name_____Work #_____ Home #_____Cell#_____
Name_____Work#_____ Home#_____Cell#_____

****

THIS SECTION TO BE COMPLETED BY A PHYSICIAN

1. Use of EpiPen®: **Dose** _____EpiPen® 0.3 mg _____EpiPen Jr.® 0.15mg

☐ EpiPen® should be used immediately after a bee/wasp sting, after food ingestion or exposure, or_____, even if the symptoms are mild. **CALL 911.**

☐ EpiPen® should be used if the symptoms and signs are progressing to a severe allergic reaction. These may include one or more of the following: rapidly progressing hives or hives all over the body, swelling, choking, hoarseness, cough, wheezing, respiratory distress, fainting, dizziness, vomiting, diarrhea, abdominal pain, or these symptoms/signs:_____. **CALL 911.**

Please note: Antihistamines, unlike EpiPens, may be given only when a school nurse is present for assessment and may not be given by non-medical staff members during the school day or on field trips.

3. Additional Comments / Instructions:

4. Name of Physician_____Date_____

_____M.D.Telephone number(s)_____
Signature
Address_____