

**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

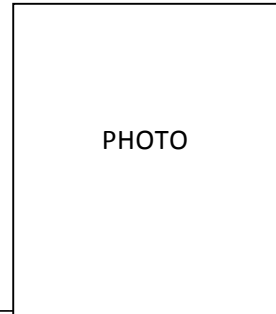
TO BE COMPLETED BY PARENT/GUARDIAN

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 _____

{EpiPen EmergPlan506}