HAWTHORN SCHOOL DISTRICT #73
Vernon Hills, Il 60061

SEVERE ALLERGY MANAGEMENT PLAN

(To be completed by parent – please use black ink)

Date _____

Student_____ Grade_____ Teacher_____

Mother _____ Phone _____ Father _____ Phone _____

Physician _____ Phone _____

CAUSE/SOURCE OF ALLERGY (Insect, food, other): _____

PREVENTION/RESTRICTIONS/MODIFICATIONS: _____

TYPICAL SYMPTOMS:

❒ coughing	❒ itching	❒ difficulty breathing
❒ sneezing	❒ swelling	❒ difficulty swallowing
❒ hives	❒ dizziness	❒ other _____

EMERGENCY CARE – IF SYMPTOMS APPEAR:

❒ Administer EPI-pen

❒ Administer Benadryl liquid – Dose: _____

❒ Call 911; transport to ER

❒ If exposed to allergen but symptoms do not appear, then _____

❒ Other:_____

INSTRUCTIONS:

❒ If school is unable to reach parents in an emergency, permission is granted to contact physician.

❒ I/we agree to release this information to the following staff, as appropriate, with the expectation that confidentiality will be respected at all times:

❒ Nurse	❒ After school caregivers/coaches
❒ Academic teachers	❒ Recess staff
❒ Related Arts teachers	❒ Bus personnel
❒ PE teachers	❒ Kitchen/cafeteria manager
❒ Substitute teachers	❒ Other _____

_____ _____

Parent Signature *Date*

File: Permanent Student Health Record
SNC: Allegy Management Plan