OCONOMOWOC AREA SCHOOL DISTRICT

EMPOWERING A COMMUNITY OF LEARNERS AND LEADERS

ALLERGY
HEALTH ACCOMMODATION PLAN
(Only use this form is epi is NOT prescribed)
District Nurse Phone: 262-560-2104
District Nurse Fax: 262-560-2106

Name	______________	School Year	______________
Birthdate	______________	School	______________
Practitioner	______________	Grade	______________
Practitioner Phone	______________	Practitioner fax	______________

The following information is helpful to your student's District Nurse and school staff in determining any special needs your child might require. Please answer the questions to the best of your ability. If you desire a conference with the District Nurse, please call **262-560-2104** for an appointment.

☐ **Allergy symptoms are no longer an issue for my child. (Please sign and return Care Plan)**

1. Allergy to: (please indicate) ______________________________

2. How long has your child had an allergy? ______________________________

3. Please indicate the severity of the reaction (circle one).
   (Not Severe) 1 2 3 4 5 6 7 8 9 10 (Severe)

4. Check signs and symptoms that your child may exhibit during an allergic reaction:
   - ❑ Itching & swelling of the lips, tongue or mouth.
   - ❑ Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough.
   - ❑ Hives, itchy rash, and/or swelling about the face or extremities.
   - ❑ Nausea, abdominal cramps, vomiting, and/or diarrhea.
   - ❑ Shortness of breath, repetitive coughing, and/or wheezing.
   - ❑ "Thready" pulse, "passing out".
   - ❑ Other______________________________

5. What medication(s) does your child take at ***home*** and how often? ______________________________

6. What allergy medication(s) will your child ***need to take during school***?

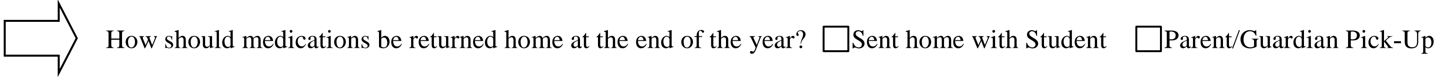
   Medication: ______________ Dose: __________ Frequency: ______________

   Medication: ______________ Dose: __________ Frequency: ______________

   *******Please supply the school with the needed medication(s) on or prior to the first day of school******

7. What, if any, side effects does your child experience from his/her medication? ______________________________

8. If allergic reaction occurs, what action should the school take?______________________________
   ____



How should medications be returned home at the end of the year? ☐Sent home with Student ☐Parent/Guardian Pick-Up

- I hereby give permission to OASD's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's practitioner with any concerns regarding medication administration. I agree to hold the Oconomowoc Area School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- I allow the named practitioner (office) to send by electronic transmission this form to the Oconomowoc Area School District for the purpose of continuing health care at school.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

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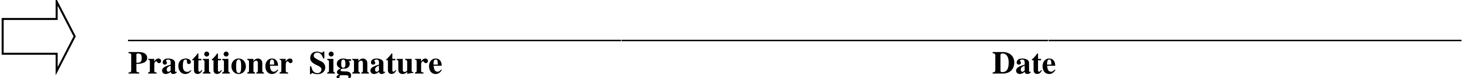
Parent/Guardian Signature **Date**



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Practitioner Signature **Date**