Winchester Public Schools

PHOTO

Individual Health Care Plan Life Threatening Allergy (IHCP) Secondary

Name: _____ D.O.B. ____ Teacher: _____ Grade: _____

Address: _____ Home Phone: _____

Parent/: _____ Cell Phone: _____ Work Phone: _____

Parent/: _____ Cell Phone: _____ Work Phone: _____

Physician: _____ Phone _____ Last exam: _____

Allergist Physician: _____ Allergy tested? Yes __ No __ Date: ____

Eczema? Yes __ No __ Treated with: _____
Asthma? Yes __ No __ Treated with:_____

Is asthma medication in school? Yes__ No __ Asthma Action Form on File? Yes__ No __

Allergic to:	**Reaction**	**Age / Date**	**Hospital /Epi-Pen**	**Anaphylaxis**
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Last reaction: _____ How was it treated? _____

Comments: _____

_____

Other Medical History: _____

_____

_____

_____

Medications Ordered:		**Location**
1. _____	Exp date: _____	_____
2. _____	Exp date: _____	_____
3. _____	Exp date: _____	_____

In elementary school arrangements can be made for epinephrine to be kept in appropriate locations.

REVISED 5/2015

Epinephrine will be sent on all field trips in the elementary and middle school.

****** Please note Benadryl will not be sent on field trips per DPH regulations.******

Permission to carry medications:		**Physician approved:**	**Parent approved:**
EpiPen	Yes _____ No _____	Yes _____ No _____	Yes _____ No _____
Benadryl	Yes _____ No _____	Yes _____ No _____	Yes _____ No _____
Asthma Med	Yes _____ No _____	Yes _____ No _____	Yes _____ No _____

Will the student be allowed to buy a school lunch on occasion? Yes _____ No _____

****For more information regarding our school lunch program, including food allergies and other dietary concerns, please contact the Director of Food Services at 781-721-7033****

Does the child wear a medic alert? Yes ___ No ___

Parents/ Guardians are responsible to notify the after school program(s) and/or bus transportation services of their child's allergies and health care needs.

Other Emergency Contacts

Name: _____ #1. Phone: _____
Relationship: _____ # 2. Phone: _____
Name: _____ # 1. Phone: _____
Relationship: _____ # 2. Phone: _____

Parent Authorization

We (I), the undersigned, are the parents/guardians of _____.
We will notify the school immediately of changes in phone numbers, addresses, and responsible emergency contact persons, and physicians, and changes in medication or health status of our child.
We (I) give permission for the nurse to contact physicians with any health or medical concerns.
We (I) give permission to share photo and information from EAAP and IHCP with appropriate school personnel.

Signature of Parent: _____ Date: _____

Signature of Nurse: _____ Date: _____