NORTH BRANCH AREA PUBLIC SCHOOLS
Inspire Dreams, Build Integrity, Instill Hope

Health Management Plan: Allergies

Student Name: _____ Grade: _____ School Yr.: _____ D.O.B._____
Classroom Teacher: _____
Parent/Guardian: _____ Preferred Phone: _____
Known Allergies: _____
_____
Health Care Provider: _____ Facility: _____

PLAN:

Accommodations for lunch time:

☐will eat at the peanut free lunch table in the cafeteria
☐may have a friend sit with him/her at the lunch table if eating a hot lunch.
☐Other: _____
_____

Classroom Food Management:

☐Student will provide his/her own snack from home.
☐Student will self-monitor his/her snacks
☐Other: _____
_____.

Plan for emergency response (epi-pens)

☐Student may physically carry an Epi-Pen on them at all times with a signed order from the physician.
☐Student will have an Epi-Pen in close proximity (ex- back-pack, classroom)
Please define: _____
_____
_____
_____.
☐Other: _____
_____.

I have read and agree that the above procedure should be followed in the event that my child has a reaction at school, or a school activity. I understand that I am responsible for ensuring that emergency medications are available for my child, this includes when my child is at school, going to and from school, and while on field trips. I understand that I must provide a completed Authorization For Medication Form for any necessary medications before they can be given.

PARENT/GUARDIAN: _____ Date:_____

☐ MD orders on file:
SCHOOL: Sunrise River PHONE: (651) 674-1100 FAX: (651) 674-1110

The following received copies and/or are trained to initiate plan:

Parent/Guardian_____ Health Office _____Para/Aide _____ Bus Garage_____Teacher(s)_____
Coach _____Other _____

**** Plan must be reviewed and signed **annually***