RE: Allergy Action Plan

Date: School Year 2026-2027

Student:_____ DOB:_____

Dear Parent or Guardian,

You indicated on your child's health history form that they have an allergy to_____.

To ensure we can provide the necessary accommodations and keep your child safe at school, we need to establish an official care plan. Please review the required steps below:

- **Physician's Care Plan:** Please have your child's physician complete, sign, and return the attached form (or their own standard allergy action plan).
    - *Note: If you do not have an upcoming appointment, your doctor's office can fax this paperwork directly to the school. (Fax: 812- 274- 8791)*
- **Emergency Medication:** Please provide the school with an EpiPen.
- **Schedule a Phone Consultation:** We need to collaborate with you to create an Individual Health Care Plan. Please call the school and leave a voicemail indicating the best times to reach you for a brief phone conversation.

**Important Reminder:** Medical action plans must be updated and resubmitted **annually** to ensure our records remain accurate.

If you have any questions or concerns, please feel free to contact the school and leave a message.

Thank you for your cooperation and for partnering with us to keep your child safe, happy, and healthy at school.

**Madison Consolidated Schools**

**Renee James, RN**

**District Nursing Coordinator**

# MADISON CONSOLIDATED SCHOOLS STUDENT INDIVIDUALIZED HEALTH CARE PLAN

Includes applicable physician orders and EAPs
(emergency action plans)

**SCHOOL YEAR: 2026-2027**

| **STUDENT INFORMATION:** 504 Plan Yes.___ No____ **ALLERGIES:** _____ | | | |
|---|---|---|---|
| **Student:** | D.O.B. | **Grade:** | **School:** |
| **Counselor:** | **BUS:** | | **Driver:** |
| **Parent:** | **Phone:** | | **Email:** |
| **Physician:** | **Phone:** | | **Fax:** |
| **Physician:** | **Phone:** | | **Fax:** |
| **School Nurse:** | **School Phone:** | | **Fax:** |

| **Medical Diagnosis:** |
|---|
| |

| Daily Medications | Notable side effects | Time of Admin |
|---|---|---|
| | | |
| | | |
| | | |

| Symptom(s) of Concern: | Intervention: |
|---|---|
| | |
| | |

| Goals: | Evaluation: |
|---|---|
| | |
| | |

| DIET: | ACTIVITY: | ENVIRONMENTAL MODIFICATIONS: |
|---|---|---|
| | | |

**SCHEDULE OF DAILY CARE:**

| | |
|---|---|
| **Breakfast** | |
| **Lunchtime**: | |
| **Afternoon:** | |

**FIELD TRIP/EXTRA-CURRICULAR ACTIVITY CONSIDERATIONS:**

**CONTINGENCY PLANNING:** (Who will provide care in event of the nurse absence)

| Trained VHA: | Sub Nurse | Health Room Assistant |
|---|---|---|
| Yes or No | Yes or No | Yes or No |

**SUPPLIES NEEDED: Parents will provide all needed supplies for treatments and orders i.e wipes, diabetic supplies, snacks or food, emergency meds,cath supplies, gtube supplies, etc.**

"I give permission for the school nurse and any pertinent staff caring for my child to follow this plan, administer medication and care for my child, contact my licensed healthcare provider if necessary, and for this healthcare information to be shared with pertinent school staff per FERPA guidelines. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices."

RN Signature:_____Date: _____

Parent Signature: _____ Date: _____

# Allergy/Anaphylaxis Emergency Health Care Plan

Fax: 812- 274- 8791

Child's Name:_____ DOB:_____
Allergy To:_____
School:_____ Grade:_____ Teacher:_____

Asthmatic: Yes or No High Risk for Severe Reaction: Yes or No

Please Mark Any Signs or Symptoms below that pertain to students:

| Systems | Symptoms | Epi | Antihistamine |
|---|---|---|---|
| _____ Contact | Ingested/ came in contact with stated Allergen that epi pen was prescribed for. **No S/S yet** | ❒ | ❒ |
| ____ Body | Itching/hives no swelling of lips tongue or mouth | ❒ | ❒ |
| ____ Mouth | Itching and swelling of the lips, tongue, or mouth | ❒ | ❒ |
| ____ Throat | Itching and or sense of tightness in the throat, hoarseness and hacking cough | ❒ | ❒ |
| ____ Skin | Hives, itchy rash, and or swelling about the face or extremities | ❒ | ❒ |
| ____ Gut | Nausea, abdominal cramps, vomiting, vomiting, and or diarrhea | ❒ | ❒ |
| ____ Lung | Shortness of breath, repetitive coughing and or wheezing | ❒ | ❒ |
| ____ Heart | “Thready” pulse, “passing out” | ❒ | ❒ |
| ____Other | _____ | ❒ | |

The severity of symptoms can quickly change! All above symptoms can potentially progress to a life-threatening situation! Please list any other signs or symptoms that may indicate exposure:_____

Special Precautions: _____
_____

1. Call the school nurse and parents/child's emergency contact
2. Call 911 immediately if Epinephrine is used
3. Monitor student and give a second dose if need after_____ minutes
4. Call Dr:_____ Number:_____

**GIVE MEDICATION according to Doctor's or State's Standing Order and DIAL 911 immediately, even if parents or physicians are unavailable!**

**Parent Signature: _____ Date:_____**

**Physician Signature:_____ Date:_____**

**Physician Printed Name: _____ Phone:_____**

**RJ 2026**




# AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION 2026/2027

Student Name: _____ DOB: _____
Parent or Legal Guardian:_____Phone: _____
Address: _____ City/State/Zip: _____
School: _____Grade: ___ Teacher: _____

Medical Condition(s): _____
_____

Authorization for the exchange of information is hereby granted between Madison Consolidated Schools and the following agency(s) and/or individual(s):

1._____ _____
Name of physician, agency, individual, etc. Phone Fax

2._____ _____
Name of physician, agency, individual, etc. Phone Fax

3._____ _____
Name of physician, agency, individual, etc. Phone Fax

Effective: 2026-2027 School year
Purpose: The purpose of the use and/or disclosure of this information is to best provide for the student's educational, physical and emotional adjustment between the hospital/ Medical office setting and the school setting.

Treatment Orders:____ Emergency Action Plans _____Health/Medical Record Information: _____

• This authorization is valid for twelve (12) months from the date of signing. At any time, I may revoke this release in writing. If I want it to expire on a different date, then that date is:___ . Revocation does not affect release of medical records made prior to the revocation. I understand that I have a right to receive a copy of this form after signing.
• I recognize that these records, once received by the school district, may not be protected by the Health Insurance Portability and Accountability Act (HIPAA), but will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

• Signing this release is voluntary. Refusing to sign it will not affect the school or district's commitment to provide a quality education for the student. However, the requested records may be required in order for the school to implement an appropriate plan of education, learning accommodations/modifications, and or health care.
• I understand for the purpose of providing the most appropriate instruction and assistance in school, I am giving my permission for mutual exchange of educational evaluations or medical evaluations.
• Parents of a student with a disability have protection under the procedural safeguards described in the law: 511 IAC-7-37-1. If I have not previously received a copy of written notice of procedural safeguards and a list of resources for help in understanding my rights, I understand these can be obtained from my child's teacher or the Special Education office.
• By my signature below, I indicate that I am the parent or legal guardian of the above named child. I authorize the release and use of the information in accordance with the rights,restrictions and understandings above to ensure health, safety and continuity of care for my child.

Parent or Legal Guardian's Signature: Date:

_____ _____