MONROE COUNTY COMMUNITY SCHOOL CORPORATION
ENGAGE. EMPOWER. EDUCATE.

Health Services Department

Food/Environmental Sensitivity Action Plan

Student name: _____ Valid for School Year: 20_____ - 20_____

School: _____ Grade: _____ Teacher: _____

Date of birth: _____

Parent/Guardian: _____

Home #: _____ Work #: _____ Cell: _____

Student has a sensitivity/minor reaction to: _____

Does the student have asthma? _____ Yes _____ No

*If yes, please complete an Asthma Action Plan if an inhaler will be kept at school.

What are the usual signs/symptoms for the student when they are exposed?

☐ Redness ☐ Rash ☐ Hives ☐ Vomiting/Diarrhea

☐ Swelling ☐ other: _____

Symptoms occur when the allergen has been: ☐Eaten ☐ Touched ☐ Inhaled ☐other _____

Please describe any special instructions for the student:

_____

_____

_____

If medication is needed following exposure, please complete a Medication Authorization Form.

Parent/Guardian Signature: _____ Date: _____

Travel RN Signature: _____ Date: _____

Health Aide Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Please be aware that this IHP may be shared with other MCCSC staff that has a legitimate educational/safety interest.