

Mumford ISD

Severe Non-Food Allergy - Individualized Healthcare Plan

Date: _____ Revised Date: _____ Campus: _____ Grade: _____
 Student Name: _____ Student ID: _____ DOB: _____
 Physician Name: _____ Phone: _____ Fax: _____
 Emergency Contact: _____ Phone: _____ Email: _____
 Diagnosis: _____ Allergies: _____
 Campus Nurse: _____ BStrohRN _____ UAP: _____

Nursing Diagnosis Concerns that could arise at school based on Doctor Diagnosis	Nursing Interventions How can the school nurse help support the student's health diagnosis	Goals What we would like the student to improve on or do	Evaluation What was the outcome of the interventions and goals
Ineffective breathing pattern related to: -bronchospasm -Inflammation of airways	Review Symptoms and sources of allergen(s) Review treatment methods, including how/when to report allergic symptoms to nurse and/or school personnel Continuously monitor school environment for potential allergens	The student will identify symptoms of allergic reaction (from mild to severe) The student will be safe in all school environments	Not Attained: _____ In Process: _____ Goal Attained: _____
Effective therapeutic regimen management related to: -ability to seek help from others	Staff/Personnel training about allergic reaction/anaphylaxis Identify student's known insect/environmental allergens	The student will be safe in all school environments The student will inform school personnel when treatment for an allergic reaction is necessary	

Parent/Guardian Statement: I/We have read this plan and agree to its implementation: _____

Parent/Guardian signature

Date