SUNMAN DEARBORN COMMUNITY SCHOOL
PARENT REQUESTED STUDENT CARE PLAN

My child has a mild/moderate allergic reaction to _____.

Student Name _____Date_____Grade____

School_____

Address_____ City_____ Zip_____

Mother_____ Phone_____ Work Phone_____

Father_____ Phone_____ Work Phone_____

Other Emergency Contact _____ Phone_____

Doctor _____ Phone_____

Health Care History and Needs _____
_____
_____
Typical Reaction: _____
How many times has your child required the doctor/hospital for this reaction? _____

Plan:
_____ Ice
_____ Call Parent
_____ Give Medication Immediately

I give permission to administer (name of medication) _____
(dosage) _____ to my child to prevent an allergic reaction.
I understand that my child will need to be picked up from school and monitored at home.
I will notify the school immediately of any changes in dose, time, physician, or discontinuation of the above medication.
I agree to absolve Sunman Dearborn Corporation and employees from any events arising from the administration of this medication.

Additional Treatment or Information:
_____
_____
_____
Give copy to bus driver(s) _____ YES _____ NO
Parent Signature_____ Date_____

This form needs to be updated and signed yearly. Revised 6/2021