ROCHESTER COMMUNITY SCHOOLS
PRIDE IN EXCELLENCE

School Year 2024-2025

ROCHESTER COMMUNITY SCHOOLS
SEVERE ALLERGY Care

Child's picture
Face only

This form must be completed, signed, and ATTACHED to an Allergy Medical Action Plan (MAP). Your child's health care provider will choose to either use their own MAP template, OR the Allergy MAP template listed on the RCS website.

Student's Name: _____ School: _____
Date of birth: _____ Age: _____
Grade: _____ Teacher**:** _____

This MAP is validated with signatures and dates, by both the licensed health care provider (Doctor of Osteopathic Medicine, D.O., Medical Doctor, M.D., Nurse Practitioner, N.P., or Physician Assistant, P.A.), and a parent/legal guardian. Recommended orders for medical interventions within this treatment plan, will expire at the end of the 2024-2025 school year.

Transportation Office Use ONLY if needed
Bus #
Driver:
Route #
Medical File

CONTACT INFORMATION

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

☐ YES ☐ NO My child has a history of receiving epinephrine for an allergic reaction.
☐ YES ☐ NO My child has asthma (If yes, higher risk for a severe allergic reaction).

☐ YES ☐ NO **REQUEST NO PEANUT OR TREE NUT LUNCH TABLE**

List **ALL** allergies that require a PRESCRIPTION for epinephrine: _____
_____

List all other allergies: _____

PARENT/GUARDIAN CONSENT

I, (parent/guardian), _____, request that my child, _____, receive the attached medical management at school, according to standard school policy. I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this entire plan, shared with individuals that need to know. Also, I give permission to use my child's picture on this plan (if I did not supply a photo).

☐ YES ☐ NO If my child is to self-carry epinephrine, I will supply the school with a back-up auto-injector.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

School Office Use ONLY
Auto-injector type:
Expiration date: