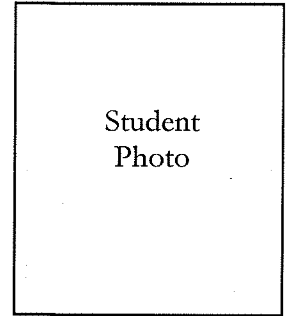
Manhasset UFSD

Allergy Action Plan School Year______



Name____D.O.B.______________

School ______________________Teacher______________Grade___________

Allergy To____

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

Give Checked Medication
(To be determined by physician authorizing treatment)

Symptom	Description		
▪ If a food allergen has been ingested but no symptoms:		☐ Epinephrine	☐ Antihistamine
▪ MOUTH	Itching & swelling of lips, tongue or mouth, mouth "feels hot"	☐ Epinephrine	☐ Antihistamine
▪ THROAT	Itching, tightness in throat, hoarseness, cough, difficulty swallowing, drooling	☐ Epinephrine	☐ Antihistamine
▪ BREATHING	Wheezing, difficulty breathing, congested	☐ Epinephrine	☐ Antihistamine
▪ STOMACH	Discomfort, nausea, vomiting, abdominal cramps, diarrhea	☐ Epinephrine	☐ Antihistamine
▪ SKIN	Flush or red face, tingling and or itching of body, palms of hands or soles of feet; hives, swelling	☐ Epinephrine	☐ Antihistamine
▪ GENERAL	Dizziness, loss of consciousness, feeling of panic or doom	☐ Epinephrine	☐ Antihistamine
▪ OTHER	____	☐ Epinephrine	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected) give		☐ Epinephrine	☐ Antihistamine

Cafeteria

Children with food allergies will be seated at the staff supervised, allergenic food free table in the cafeteria unless otherwise specified by parent.

☐ **I do want my child seated at the allergenic food free table.**
☐ **Please allow my child to eat at a non restricted table.**

Healthcare Provider's Name:____________________________________ **Phone**_____________**Date**__________

As healthcare provider, I certify the medication administration order and these directions as the basis for formulating an Emergency Care Plan
Healthcare Provider's Signature:_________________________ **Stamp**___________________________________

The Parent/guardian signature authorizes the school to share this information with school staff on a "need to know" basis.

Parent/ Guardian Signature:____**Date:**____________________

Home phone_____________________ **Cell phone**______________________**Work:** _________________________

REVISED 2/2022

Manhasset Public Schools

Health Offices

ANAPHYLAXIS / ALLERGY

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

I request that my child ______________________Grade ________ receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication. Furthermore, I understand it is my responsibility to immediately notify the Health Office of any change in the type, dosage, or frequency of administering the medication.

Signature (Parent or Guardian): ____

Address: ____

Telephone: Home: _______________ Work: ______________________________________

B. TO BE COMPLETED BY LICENSED HEALTH CARE PRESCRIBER:

I request that my patient, listed below, receive the following Medication:

Name: __________________________ Date of Birth: ________________________________

Diagnosis: ____ICD-9 code____________

Name of Medication: ____

Epinephrine: ____

Dose to be given/Route of Administration: ____

Antihistamine: ____

Dose to be given/Route of Administration:____

Other (e.g., inhaler-bronchodilator, if asthmatic):_____________________________

Dose to be given/Route of Administration:____

Possible Side Effects and Adverse Reactions (if any): _____________________________

State which of these medications this child can self-administer:

____

Name of Licensed Prescriber and Title (Please Print): _____________________________

Prescriber's Signature: _______________________ Date: ______ Stamp _______________

Address: ___________________________________ Phone: __________________________

Original Required

Revised 2/2022