5426E

Manhasset Public Schools

Health Offices

Allergy Action Plan School Year_____

Name_____D.O.B._____

School _____Teacher_____Grade_____

Allergy To_____

Student Photo

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

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

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Home phone:_____ Cell phone:_____Work: _____

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: _____