

West Bloomfield School District
5810 Commerce Rd.
West Bloomfield, MI 48324

Food Allergy and Anaphylactic Emergency Plan

To ensure the safety and well-being of all children, families must provide clear and accurate allergy information for their child. A separate form must be completed for each individual allergy. Please list only the medications required for that specific allergy on each form.

For example:

- Peanut allergy → EpiPen (1 form)
- Environmental allergy → Inhaler (1 form)

If multiple medications are required for a single allergy (e.g., inhaler and EpiPen), please list them together under that specific allergy.

Both prescription and nonprescription medications require a completed emergency plan form signed by a physician and parent/guardian.

TO BE COMPLETED BY PARENT/GUARDIAN:

STUDENT'S NAME:	DATE OF BIRTH:	TODAY'S DATE:
SCHOOL:	TEACHER:	GRADE:
PARENT/GUARDIAN CONTACT INFORMATION		
NAME:	RELATIONSHIP:	PRIMARY PHONE:
NAME:	RELATIONSHIP:	PRIMARY PHONE:

TO BE COMPLETED BY THE PHYSICIAN:

Allergic to (one allergy per form):
Medications Listed on Action Plan
NAME OF MEDICATION #1 _____ DOSAGE: _____ Expiration Date: _____ ☐ Prescription (must be in the original pharmacy container with the original prescription label) ☐ Non-Prescription (must be in the original store box and labeled clearly with the child's first and last name) STORAGE: ___Room Temperature ___Refridgerated
NAME OF MEDICATION #2 _____ DOSAGE: _____ Expiration Date: _____ ☐ Prescription (must be in the original pharmacy container with the original prescription label) ☐ Non-Prescription (must be in the original store box and labeled clearly with the child's first and last name) STORAGE: ___Room Temperature ___Refridgerated
NAME OF MEDICATION #3 _____ DOSAGE: _____ Expiration Date: _____ ☐ Prescription (must be in the original pharmacy container with the original prescription label) ☐ Non-Prescription (must be in the original store box and labeled clearly with the child's first and last name) STORAGE: ___Room Temperature ___Refridgerated

Food Allergy and Anaphalic Emergency Plan

TO BE COMPLETED BY THE PHYSICIAN:

Mild Symptoms

Please check all that apply:

- ☐ Itchy or runny nose, sneezing
- ☐ Itchy mouth
- ☐ A few hives or mild itching
- ☐ Mild nausea or stomach discomfort

Other (please list):

Step by step action plan if mild symptoms occur:

Step 1:

Step 2:

Step 3:

Additional steps:

Severe Symptoms

Please check all that apply:

- | | |
|---|---|
| ☐ Pale or bluish skin, faintness, weak pulse, or dizziness. | ☐ Many hives over the body or widespread redness. |
| ☐ Shortness of breath, wheezing, or repetitive coughing. | ☐ Repetitive vomiting or severe diarrhea. |
| ☐ Tight or hoarse throat, difficulty breathing, or trouble swallowing. | ☐ Anxiety, or confusion. |
| ☐ Significant swelling of the tongue or lips. | ☐ A combination of symptoms occurring in different areas of the body at the same time. |

Other (please list):

Step by step action plan if severe symptoms occur:

Step 1:

Step 2:

Step 3:

Additional steps:

I certify that I am a licensed healthcare provider and have reviewed and completed this form to the best of my knowledge. The information provided is accurate and reflects the current health status of the child. Any medical conditions, restrictions, and/or recommendations have been noted, and the child is able to participate in program activities as indicated above.

PHYSICIAN'S NAME:	PHYSICIAN'S PHONE:	PHYSICIANS ADDRESS:
PHYSICIANS' SIGNATURE:		DATE:
X		X

TO BE COMPLETED BY CHILDS LEGAL PARENT/GUARDIAN:

I agree with this medical plan as written and for the school staff to share this information with those that need to know and for staff to contact the treating healthcare professional for clarification of this plan, if needed. I authorize school personnel to contact the above physician with questions or concerns relative to this authorization and medication.

PARENT/GUARDIAN NAME:	PARENT/GUARDIAN PHONE:	PARENT/GUARDIAN ADDRESS:
PARENT/GUARDIAN SIGNATURE:		DATE:
X		X