ALLERGY

Mamaroneck Union Free School District

EMERGENCY ACTION PLAN

Student's name: _____ DOB: _____ Grade/class: _____

School: ❒ Central ❒ Chatsworth ❒ Mamaroneck Avenue ❒ Murray ❒ Hommocks ❒ High School ❒ Other _____

ALLERGY TO: _____

PHOTO ID

Mother/Guardian: _____ (H) _____

(C): _____ (W) _____

Father/Guardian: _____ (H) _____

(C): _____ (W) _____

Emergency Contact: _____ (H) _____

(C): _____ (W) _____

Allergy Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Asthmatic: ❒ Yes* ❒ No * High risk for severe reaction

❒ **If checked, give epinephrine immediately for ANY symptoms if allergen was likely consumed.**

Signs of an allergic reaction include:

SYSTEMS:	SYMPTOMS:
• MOUTH	itching & swelling of the lips, tongue or mouth
• THROAT	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
• SKIN	hives, itchy rash, and/or swelling about the face or extremities, widespread redness
• GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
• LUNG	shortness of breath, repetitive coughing, and/or wheezing
• HEART	"thready" pulse, "passing-out", pale, blue, dizzy
• Other	Feeling something bad is about to happen
	Any combination of symptoms from different body parts

THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL ABOVE **SYMPTOMS CAN** POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION!

ACTION:

1. Call school nurse, or administration if the school nurse is not available.
2. If an allergic reaction is suspected, give Epinephrine or assist student to administer their own Epinephrine. Please note time Epinephrine was administered
   - To administer an Epinephrine, you must have received training from your school nurse
3. Lay student flat and raise legs. If breathing difficulty or they are vomiting let them sit up or lie on their side.
4. Call 911. Alert the need for a paramedic to administer epinephrine.
5. Alert emergency contact.
6. Inform building administration that 911 has been called.
7. Keep the student calm.

Emergency Medications: ❒ Student is Independent and carries his/her own medication

	Name of drug	Dose	Name of drug	Dose
1.	**Epinephrine AI***	❒Junior.15mg ❒Adult .30mg	**Epinephrine Nasal Spray**	❒ 1mg ❒ 2 mg
2.	Antihistamine* will be sent on field trips only if student is self-directed			

* Medication permission sheet(s) must be on file in the Health Office

Do not hesitate to administer medication or call 911 even if parents cannot be reached!

Comments/Special Instructions: _____

Signature of parent/guardian: _____ Date: _____

Signature of Health Care Provider: _____ Date: _____

Parent signature gives permission to speak to child's physician/practitioner and school staff as needed. 4/26

PARENT – PLEASE COMPLETE THE OTHER SIDE OF FORM

ALLERGY INFORMATION FORM

Dear Parent(s) or Guardian(s):

Please complete the information below and return it to the Health Office as soon as possible. If any changes occur during the school year, please notify the school nurse.

Name of student: _____ Grade/class: _____

General History:

❍ Please list what your child is allergic to and what happens if he/she eats this or comes into contact with it:

 # 1 ALLERGIC TO: _____

What happens to your child when he/she eats this or comes into contact with this?

_____

When was the last time your child had a reaction to this? _____

 # 2 ALLERGIC TO: _____

What happens to your child when he/she eats this or comes into contact with this?

_____

When was the last time your child had a reaction to this? _____

 # 3 ALLERGIC TO: _____

What happens to your child when he/she eats this or comes into contact with this?

_____

When was the last time your child had a reaction to this? _____

❍ Medications child takes at home for his/her allergy:

Name	Dose	How often
_____	_____	_____
_____	_____	_____

• Side effects of medication that your child experiences: _____.

❍ Following an allergic reaction, have you ever had to give your child:

❍ Antihistamine_____ ❍ Epinephrine Auto Injector/Nasal Spray

❍ Number of times your child has had to be taken to an emergency facility for an acute allergic reaction in the past 12 months: _____

❍ Additional information/instructions: _____

_____

Signature of parent/guardian: _____ **Date:** _____

4/26

PLEASE COMPLETE THE OTHER SIDE OF FORM

MAMARONECK

PUBLIC SCHOOLS

1000 W. Boston Post Rd.

Mamaroneck NY 10543

914-220-3000

CONSENT TO RELEASE MEDICAL INFORMATION

School: Central ❍ Chatsworth ❍ Mamaroneck Avenue ❍ Murray
❍ Hommocks ❍ High ❍ Other _____

Date: _____

Name of physician/practitioner: _____
Street Address: _____
City/Town; State; Zip: _____
Phone: _____

Name of student: _____
Date of birth: _____

To: Physician/practitioner

Please release any medical documentation and/or other information on the above named patient to the school nurse, and/or the school physician as maybe requested by a representative of the District's Health Office.

_____ _____
Parent/Guardian signature Date

PARENT/GUARDIAN SIGNATURE DENOTES PERMISSION TO SHARE INFORMATION WITH STAFF ON A NEED-TO-KNOW BASIS.

MAMARONECK UNION FREE SCHOOL DISTRICT

Provider and Parent Permission to Administer* EPINEPHRINE* Medication at School/School - Sponsored Events

To Be Completed by Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/Counselor_____ School: _____

I request the school nurse give the medication listed on this plan; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Email **Phone Where We Can Reach You**

To Be Completed by Health Care Provider-Valid for the School Year

Diagnosis: Allergy: _____

Medication: ☐ **Epinephrine Auto Injector** ☐ **Epinephrine Nasal Spray**

Dose: ☐ **0.15 mg** ☐ **0.3 mg Route: IM Auto Injection** **Dose:** ☐ **2 mg** ☐ **1mg Route: Nasal Spray**

Time: PRN Severe Allergic Reaction

Recommendations: Call 911 if administered; call parent/guardian; call administrator

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**
NYS law requires both provider attestation that the student has demonstrated they can effectively self- administer inhaled respiratory rescue medications, epinephrine, Insulin, glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____ STAMP

Name/Title of Prescriber (Please Print) **Date**

_____ _____

Prescriber's Signature **Phone**

PLEASE RETURN TO THE SCHOOL NURSE

MAMARONECK UNION FREE SCHOOL DISTRICT

Provider and Parent Permission to Administer* ANTIHISTAMINE * Medication at School/School - Sponsored Events

To Be Completed by Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/Counselor_____ School: _____

I request the school nurse give the medication listed on this plan; trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Email **Phone Where We Can Reach You**

To Be Completed by Health Care Provider-Valid for the School Year

Diagnosis: Allergy _____

Antihistamine: _____

Dose: _____**mg**_____ **Route: PO** **Time: PRN Allergic Reaction**

PRN, for what symptoms: _____

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**
NYS law requires both provider attestation that the student has demonstrated they can effectively self- administer inhaled respiratory rescue medications, epinephrine, Insulin, glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____

Name/Title of Prescriber (Please Print) **Date**

_____ _____

Prescriber's Signature **Phone**

Stamp

PLEASE RETURN TO THE SCHOOL NURSE

MAMARONECK UNION FREE SCHOOL DISTRICT

PROVIDER ATTESTATION AND PARENT PERMISSIONS FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ **DOB:** _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively and may carry and use this medication (with a delivery device if needed) independently at any school/school- sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector and/or Epinephrine Nasal Spray
- ☐ Allergy and requires Antihistamine
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ _____ (State Diagnosis) which requires rapid administration of _____ (Medication Name)

Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school-sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____

STAMP

PLEASE RETURN TO THE SCHOOL NURSE

MAMARONECK UNION FREE SCHOOL DISTRICT

GUIDELINES FOR STUDENTS WITH FOOD ALLERGIES (Secondary Level)

WHO	RESPONSIBILITIES
PRINCIPAL/ ASSISTANT PRINCIPALS	○ Inform custodial staff that an **All** tables needs to be thoroughly cleaned any time food is consumed in the lunchroom, using a fresh cloth to prevent cross contamination ○ Review educational material annually from the school nurse for **Sign and Symptoms of an Allergic Reaction** ○ Identify students with allergies who may be eligible for a 504 plan and refer to the 504 committee ○ Will be given a copy of Emergency Action Plan (EAP) for each student from the nurse ○ Inform staff that food rewards are not to be used ○ Inform staff that parent/guardian must be informed about food celebration prior to the class event (Hommocks Middle School) ○ Provide walkie-talkies for communication between Health Office, cafeteria and outdoor recess ○ Maintain a list of staff members with current CPR/AED certification ○ Develop protocols and train staff as to specific roles in an emergency
NURSE	○ Request all medical history information from parent/guardian ○ Be available for parent/guardian to discuss students' needs ○ Request signed consent from parent/guardian to speak to the Healthcare Provider ○ Provide parent/guardian with the following forms: • *Consent Form* • *Medication Permission Sheet/Attestation form for self-carry and use* • *Emergency Action Plan (EAP)* • *Guidelines for Students with Food Allergies* ○ Ensure that medication and forms are received in a timely manner ○ Post the **Signs and Symptoms of an Allergic Reaction** in the cafeteria ○ Encourage parent/guardian to provide the Food Service Company with information on student's allergies ○ Encourage the parent/guardian to contact the facility where a school trip is planned ○ Distribute educational material annually for **Sign and Symptoms of an Allergic Reaction** ○ Collaborate with administration to train staff and provide a safe environment ○ Encourage Epinephrine training for all staff members ○ Provide teachers with Emergency Action Plan (EAP) ○ Epinephrine • Request Medication Permission Sheet and EAP from parent/guardian • Epinephrine will be placed in a marked unlocked cabinet in Health Office • Place sign on med cabinet stating location of Epinephrine in Health Office • Offer Epinephrine training for staff members • Have trainees sign off on Epinephrine training form • Epinephrine trained staff will be shown where students Epinephrine Auto Injectors are kept in the Health Office • If student is designated Independent, student may self-carry Epinephrine Auto Injector ○ Will not determine and/or approve safety of foods ○ Encourage student to advocate for him or herself

TEACHER	○ Support parents/guardians of children with food allergies ○ Review educational material annually from the nurse for **Signs and Symptoms of an Allergic Reaction** ○ Post the "**Signs and Symptoms of an Allergic Reaction**" in a visible area in the classroom ○ Place a copy of the Confidential Student Health list and copies of EAP, s in the substitute folder along with the sign and symptoms of an allergic reaction handout ○ Avoid the use of identified allergens in class projects, parties, holidays and celebrations, arts, crafts, science experiments, cooking, snacks, or rewards. Modify class materials as needed. ○ Inform parent/guardian about food celebration prior to the class event (Hommocks Middle School) ○ Will not determine and/or approve safety of foods ○ Will make sure classroom and lunchtime aides are aware of student allergies (Hommocks Middle School) ○ Encourage hand washing ○ Communicate rules and expectations about bullying related to food allergies ○ Class Trips: • Notify School Nurse at least **two weeks** in advance of trip • Notify parent/guardian of class trips and if an off-site food service will be used, provide parent/guardian with contact information • Trained teacher or designee will carry students Epinephrine and emergency information • Take cell phone on class trips ○ Store lunches of allergic students in a separate bag on class trips (Hommocks Middle School)
PARENT/ GUARDIAN	○ Notify the School and Health Office of the students' allergies ○ Work with the school team to develop an emergency action plan(EAP) that accommodates the students' needs, on the school bus, during the school day and if needed school-sponsored activities. ○ Sign consent to release medical information from the students Health Care Provider ○ Provide written medical documentation, instructions, and medications as directed by a Health Care Provider. Include a photo of the student on written forms. ○ Provide properly labeled medications (in original labeled box/bottle from pharmacy) and replace medications after use or upon expiration. ○ Provide nurse, and keep current, all pertinent medical information on student, including medicine and medicine orders ○ Provide emergency contact information and keep it current ○ Educate the student in the self-management of their food allergy including: • safe and unsafe foods • strategies for avoiding exposure to unsafe foods • symptoms of allergic reactions • how and when to tell an adult they may be having an allergy-related problem • how to read food labels ○ Speak to student about not sharing food items ○ Provide students' own lunch from home if necessary ○ Contact the Food Service Company to advise and discuss the students' food allergies. Contact information is available on the district website ○ Contact the facility where a school trip is planned ○ Provide student with medical alert bracelet if desired