BOTH SIDES OF THIS FORM MUST BE COMPLETED

Student Photo

Allergy Action Plan School Year _____

Name _____ D.O.B. _____ 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)	
▪ 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:** _____

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

Authorization for Administration of Medication

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: _____ Business: _____

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

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

Name of Student: _____Date of Birth_____

Diagnosis: _____ ICD-9 code_____

Name of Medication: _____

Prescribed Dosage, Frequency and Route of Administration:

_____

Time to be taken during school hours: _____

In the event of a field trip, can this dose be held? Yes ___ No ___

Duration of Treatment: _____

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

Other Recommendations: _____

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

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

Please return to MANHASSET MS/HS HEALTH OFFICE –
ATTN: Jeanne Clark, BSN, RN / Joann Marcucci, RN MS
Phone # (516) 267-7520 Fax # (516) 267-7524