

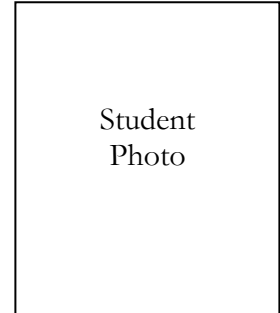
# Manhasset UFSD

## 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)

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

<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
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<input type="checkbox"/> Epinephrine	<input type="checkbox"/> 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: \_\_\_\_\_