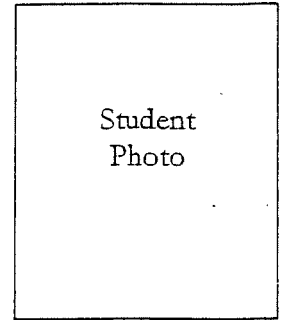


**BOTH SIDES OF THIS FORM MUST BE COMPLETED**

Allergy Action Plan School Year \_\_\_\_\_



Student  
Photo

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

**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