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 auto injector or assist student to administer his/her own Epinephrine auto injector. 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	Amount
1. Epinephrine auto injection*	❒ Junior (0.15 mg) or ❒ Adult (.30 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. 4/16

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_____ ❍ An Epi pen (epinephrine)

❍ 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: _____

❍ Should your child be seated at an *allergy alert* table in the lunchroom? ❍ Yes ❍ No

❍ Should your child's classroom be designated an *allergy alert* classroom? ❍ Yes ❍ No

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

4/16

PLEASE COMPLETE THE OTHER SIDE OF FORM