

NISKAYUNA CENTRAL SCHOOL DISTRICT EMERGENCY ALLERGY ACTION PLAN

PARENT/GUARDIAN

Student Name: _____ DOB: _____ Grade: _____
Identified Allergen(s): _____
Asthma: ☐ Yes ☐ No Other relevant concerns: _____

CONTACT INFORMATION

Mother's Name: _____ Phone: _____
Cell: _____
Father's Name: _____ Phone: _____
Cell: _____
Emergency Contact 1: _____ Phone: _____
Cell: _____
Emergency Contact 2: _____ Phone: _____
Cell: _____

A SERIOUS ALLERGIC REACTION MAY INCLUDE ANY OR ALL OF THESE SYMPTOMS:

- General: Dizziness, loss of consciousness, feeling of panic or doom
- Mouth: Swelling of lips, face, tongue, throat; a report that the mouth "feels hot"
- Breathing: Wheezing, difficulty breathing, congested cough, tightness in throat
- Stomach: Discomfort, nausea, vomiting, abdominal cramps, diarrhea
- Skin: Hives, swelling, rash

THIS INFORMATION MUST BE FILLED OUT BY A HEALTH CARE PROVIDER ONLY

When you observe any of the above symptoms, initiate the following care plan as prescribed by the student's healthcare provider:

- BENADRYL: ☐ NO ☐ YES Dosage: _____
Directions for administration: _____
- EPINEPHRINE: ☐ NO ☐ YES Dosage: _____
Directions for administration: _____

If epinephrine is given, 911 must be called. Advanced Life support is required with the use of epinephrine.

- ☐ Treatment should be initiated immediately following exposure without symptoms
- ☐ Treatment should be initiated only with appearance of symptoms
- ☐ This student's epi-pen will be kept in nurses' office and will accompany student on off campus activities.
- ☐ This student has been trained to administer and may self-carry EpiPen in/on backpack/waist pack/or person.

Physician Name: _____ Phone: _____
Preferred Hospital: _____ Phone: _____

Healthcare Provider Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

The Parent/Guardian signature authorizes the school nurse to share this information with school staff on a need-to-know basis and to contact the healthcare provider with any questions or concerns. In the event of an emergency, this plan will be initiated and parents contacted. This plan is in effect for the current school year and summer school if applicable.

NISKAYUNA CENTRAL SCHOOLS INDIVIDUAL HEALTH CARE PLAN FOR SEVERE ALLERGIES

- **BUS** - Parent should alert bus driver of student's allergy and medications
 - Student will sit at front of bus: ☐ Yes ☐ No
 - Other (specify): _____
- **FIELD TRIP PROCEDURES**
 - Epi-pen must accompany student during off campus activities
 - Student should remain with teacher or parent/guardian during entire field trip:
☐ Yes ☐ No
 - Staff members on trip must be trained in Epi-pen use and aware of this plan
- **CLASSROOM (for students with food allergies)**
 - This student is allowed to eat only the following foods:
 - ☐ Foods approved by PARENT/GUARDIAN
 - ☐ Middle or high school student will be making his/her own decision
 - ☐ Alternative snack will be provided by parent/guardian (may be kept in classroom)
 - ☐ Classroom projects should be reviewed by teaching staff to avoid specified allergens
 - ☐ Other: _____
- **CAFETERIA (for students with food allergies)**
 - ☐ Student will sit at specified allergy free table
 - ☐ No Restrictions
- **ATHLETICS (on or off campus)**
 - Parent/Guardian will inform coach via family ID regarding the student's allergy.
 - Student will carry an EpiPen to all practices and games OR give to coach to carry in emergency medical kit. Parent/Guardian must be aware of these arrangements
- **EXTRACURRICULAR ACTIVITIES (on or off campus)**
 - Parent/Guardian will inform teachers, advisors or other supervisory personnel via field trip permission forms or personally, regarding the student's allergy
 - Student is trained in use of EpiPen and can self-administer: ☐ Yes ☐ No

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Copy given to parent: ☐ Yes ☐ No