Mayfield City Schools
EVERY STUDENT. EVERY DAY.

Allergy Action Plan

The following section must be completed by the PARENT:

School:	Grade:	Year:
Student's Last Name: First Name:		☐ M ☐ F Date of Birth:

I have read and understand the Mayfield City School guidelines for giving medications. I request authorized school personnel to follow the allergy action plan listed below. I agree to see that the medications are delivered to the school; to notify if there is a change in physicians; to notify if the medication, dosage, or procedure is changed or discontinued. I give my consent to the school nurse to send and/or receive information related to my child's health, as they deem appropriate for the duration of this order as noted above.

____/____/_____ _____ (_____) _____ (_____) _____
Date | Parent/Guardian Signature | Home/Cell Phone | Emergency Phone

Allergic Reaction Specifics

The following section must be completed by the LICENSED PRESCRIBER:

Allergy/Medical Diagnosis:

Exposure Type: ☐ Eating/Drinking ☐ Breathing ☐ Touching ☐ Stings/Bites ☐ Other: _____

Symptoms of Allergic Reaction:

☐ Skin:
- ☐ Hives
- ☐ Rash
- ☐ Swelling of Face, Arms, Neck

☐ Gut:
- ☐ Nausea
- ☐ Cramping
- ☐ Vomiting
- ☐ Diarrhea

☐ Lungs:
- ☐ Shortness of Breath
- ☐ Repetitive Coughing
- ☐ Wheezing

☐ Heart:
- ☐ Fainting
- ☐ Pale
- ☐ Bluish Skin
- ☐ Weak Pulse
- ☐ Low Blood Pressure

☐ Mouth:
- ☐ Lips- Itching, Swelling, Tingling
- ☐ Tongue- Itching, Swelling, Tingling

☐ Throat:
- ☐ Hoarseness
- ☐ Throat Feels Tight
- ☐ Hacking Cough

☐ Other: _____

Recommended Preventions:

☐ School personnel do **NOT** need to monitor student meals/snacks. Child can self-monitor.
☐ Student can self-monitor and may purchase school lunch or la carte items from food service.
☐ Student may purchase school lunch.
☐ The student is **ONLY** allowed to eat foods supplied by parent/guardian (unless written permission from parent is obtained by the classroom teacher or principal for special events).
☐ Student must sit at a lunchroom table designated as Food/Allergy/Nut-Free.
☐ List the allergy on the Student Health Alert list to be shared with necessary staff.

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Treatment Plan

The following section must be completed by the LICENSED PRESCRIBER:

A: In the event of a possible exposure, but there are no symptoms of a reaction: ☐ Call Parent/Guardian for instructions ☐ Proceed directly to the treatment outlined below
B: In the event of a known exposure, but there are no symptoms of a reaction: ☐ Call Parent/Guardian for instructions ☐ Proceed directly to action C
C: In the event of an exposure and symptoms, the school staff will immediately start treatment plan below: 1. _____ 2. _____ 3. _____ 4. 911 will always be called if a life-threatening reaction occurs or when an EPI Pen has been administered. 5. Parent/Guardian will be called immediately.

(Licensed Prescriber's Stamp)	Licensed Prescriber's Printed Name: _____ Licensed Prescriber's Signature: _____ Date: _____/_____/_____ Telephone Number: (_____) _____

Rev 5/22

***Please note a new form is required every school year**

A Medication Administration Form Must Be Completed for Each Medication That is Listed on This Plan

Gates Mills • Highland Heights • Mayfield Heights • Mayfield Village

Baker Administration Building
1101 SOM Center Road – Mayfield Hts., OH 44124-2006
Phone: 440-995-6800 – Fax: 440-995.7205

Dr. Michael J. Barnes, Superintendent
Mr. Scott C. Snyder, Treasurer