MAYFIELD CITY SCHOOLS
HEALTH SERVICES

ALLERGY ACTION PLAN

Picture

(Copies of this completed form will be distributed to necessary school personnel and attached to Medical Authorization form.)

Student _____Date of birth_____
Grade/classroom_____
Allergic to_____
Exposure by: _____eating/drinking _____breathing _____touching _____stings/bites

Has this student experienced a life-threatening reaction ? ____ yes ____ no

Symptoms of an allergic reaction: Please circle all that this student has experienced.

- **Mouth Lips, tongue itching, swelling, tingling**
- **Skin Hives, itchy rash, swelling of face or arms and legs**
- **Gut Nausea, cramping, vomiting, diarrhea**
- **Throat Hoarseness, throat feels tight, hacking cough**
- **Lungs Short of breath, repetitive coughing, wheezing**
- **Heart Fainting, pale, skin is bluish, pulse is weak, low blood pressure**
- **Other_____**

RECOMMENDED PREVENTION: Please check accommodations needed for your child

_____ School Personnel do not need to monitor his meals/snacks. Child can self-monitor.

_____ Child can self-monitor and may purchase school lunch and la carte items from food service. (Parent responsible for reviewing the menu.)

_____ Child may purchase school lunch.

_____ The student is only allowed to eat foods supplied by parent/guardian unless written permission from the parent is obtained by the classroom teacher or principal for special events.

_____ Child must sit at a lunchroom table designated as Food Allergy/Nut-free.

_____ Please list the allergy on the Student Health Alert list to be shared with necessary staff.

TREATMENT PLAN:

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.

***This does not replace the district requirements for Medication Authorization Forms.**

_____ _____ _____
Physician Phone Date

_____ _____ _____
Parent/guardian Phone numbers Date