**Food/Environmental Allergy Treatment Plan**

**\*Please note that this EMERGENCY ACTION PLAN will be shared with South Hackensack Memorial School staff members that are DIRECTLY involved in your child’s daily activities. This sharing of information is to ensure the safety and health of your child.**

|  |  |  |
| --- | --- | --- |
| **Students**  **Name:** | **Students**  **Grade:** | **Students**  **Teacher:** |

**ALLERGY TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*If your child HAS A FOOD ALLERGY to eggs, nuts, flour or dairy, please indicate if he/she CAN be in the same room with those products by checking off one of the following boxes and signing:**

* **Yes, my child HAS an allergy to an above mentioned food product, but CAN be in the same room with those consuming them. I will supply the teacher with alternate “treats” for my child on days of celebration.**
* **Yes, my child HAS an allergy to an above mentioned food product and CANNOT be in the same room with those consuming them.**

**\*\*Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

**Please circle all symptoms exhibited with the allergic reaction:**

* **Mouth/Oral:** Swollen Tongue, Tingling, Swollen Lips, Itchiness within the mouth, Hacking Cough, Hoarseness
* **Skin:** Hives, Itchy Rash, Swelling of the face or extremities
* **Gastrointestinal:** Nausea, Vomiting, Diarrhea, Abdominal pain
* **Respiratory:** Shortness of Breath, Wheezing, Chest Tightness
* **Cardiovascular:** Fainting, Dizziness, Pale, Sweating, Rapid Heartbeat, Slow Heartbeat
* **Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatments: To be filled out by physician:**

* **Epi-Pen or Epi-Pen Jr. YES or NO**
* **Student CAN self-carry/self-administer Epi-Pen: YES or NO**
* **If YES, student has demonstrated proper use of Epi-Pen on:**

**Date: \_\_\_\_\_\_\_\_\_\_\_**

* **Antihistamine**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Other**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Stamp**

**Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**