

MONTOURSVILLE AREA SCHOOL DISTRICT
INDIVIDUAL STUDENT
ALLERGY ACTION PLAN

Dear Parent/Guardian:

You have told us that your child has an allergy that may require medication while in school. Food and insect allergies can be life threatening. Our goal is to minimize the risk of accidental exposure while in the school setting. Please complete the allergy action plan below and return it to the school nurse. The information will be shared with the appropriate personnel such as your child's teacher(s). This information will help us work with your child to minimize unnecessary restrictions, feelings of being treated differently and possible absenteeism. As always, please inform your child's school nurse of any changes in his/her medical condition or medication.

Thank you,

School Nurse

School year ____ - ____

Student's Name _____ Grade: _____

ALLERGY TO: _____

Physician treating allergy: Dr. _____ Phone: _____

Emergency contacts:

Mother: _____
Home # _____
Work # _____
Cell # _____

Father: _____
Home # _____
Work # _____
Cell # _____

Briefly describe the allergic reaction (hives, nausea, vomiting, shortness of breath etc.)

Medication given for this allergy _____ dose _____ route _____

It is the parent's responsibility to provide the school with this medication.

Does your child understand the allergy and what he/she should do to manage it? Yes No

I understand if _____ has an allergic reaction,
Student's full name

the school nurse will follow the individual allergy action plan and the Montoursville Area School District Allergic Reaction Plan (found on the nurse's website).

Parent Signature

Date

Must be completed each school year.

