380 Washington Ave Roosevelt, NY 11757
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CLC STUDENT SPECIFIC ALLERGY EMERGENCY CARE PLAN

PERIOD OF SCRIPT

July 1, 2024 to June 30, 2025

Student Name:_____ **D.O.B:** _____

***Please indicate specific Allergies or NKA for no Allergies**

- ☐ ALLERGIES:_____
- ☐ NKA

Please (√) one and complete information as required.

- ☐ No Action Plan required at present
- ☐ Action Plan

Medication(s) to be given at school for an allergic reaction/anaphylaxis:

Benadryl: Yes☐ No ☐	Strength:	Dosage to be given:
Frequency/Time to be taken:		Route of Administration:
Additional Consideration:		
Epinephrine: Yes ☐ No ☐	Strength:	Dosage to be given:
Frequency/Time to be taken:		Route of Administration:
Additional Considerations: ☐ Treatment should be initiated immediately following exposure w/o warning for symptoms per healthcare provider ☐ Treatment should be initiated ONLY following the appearance of symptoms (per healthcare provider)		
***Health Care Provider's Name (Print)**		**License #**
***Health Care Provider's Signature:**		**NPI#**
***Date:**	**Phone #:**	**Stamp:**

Parent's Authorization (To be completed by the Parent):

I request that my child named above, receive medication as prescribed by his/her physician above. The medication is to be furnished by me in the properly labeled original container from the pharmacy, which will be stored at the CLC Nursing Office. I understand that the school nurse will administer the medication. 911 will be contacted if epinephrine is administered, and my child will be transferred to the nearest hospital.

Parent/Guardian's Name (Print):	**Parent/Guardian's Signature:**	**Date:**

CLC NURSING DEPARTMENT

Allergy Emergency Care Plan reviewed by 1st school nurse: _____ Date: _____

Allergy Emergency Care Plan reviewed by 2nd school nurse:_____ Date: _____