# ALLERGY INFORMATION FORM AND ACTION PLAN

Student Name______________________________________ Birth Date_____________

Grade________ Teacher_____________________

Emergency contact #(s) for parent(s)__________________________________________

Care Provider/Physician________________________________Phone________________

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Please provide the following information:

**Specific Allergy (s)** **Reaction** **Medications/Treatment**

**Does your child have an Epinephrine Pen? Yes____ No____**
**If yes, do we have one kept at school in the division office? _______________________________**
**Do you authorize your child to carry an epi pen in their backpack? ________________________**

**Specific Instructions for school nurse and staff if an allergy attack occurs at school:**
(Attach written instructions from physician if medication is to be given and school does not have this on file)

**DOES YOUR CHILD RIDE THE BUS** ___full time ___part time ___not at all

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As the parent of the above named student, I authorize an exchange of information to occur between the OES nursing staff and the physician or health care provider listed above.

________________________________ __________________
Parent signature Date

**For School Staff:**
Location of additional student Epipens__________________________________________
Designated caregivers/Epipen Certified________________________________________

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