

ALLERGY INFORMATION FORM AND ACTION PLAN

Student Name _____ Birth Date _____

Grade _____ Teacher _____

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

Care Provider/Physician _____ Phone _____

Please provide the following information:

Specific Allergy (s)	Reaction	Medications/Treatment
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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

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 _____