Oregon Episcopal School

ALLERGY INFORMATION FORM AND ACTION PLAN

Academic Year: 20____-20____

Student's Name: _____

Date of Birth: _____ Grade: _____ Teacher/Advisor: _____

Emergency contact number(s) for parent(s): _____

Primary Care Provider: _____Phone: _____

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 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_____