



Annual Student Allergy Information/Emergency Plan

Student Name _____ DOB _____

Parent/Guardian _____ Home Phone _____

Home Address _____

Mother Work _____ Father Work _____

Mother Cell _____ Father Cell _____

We understand that your child has an **ALLERGY** to _____ which could require medication and/or care. Describe what symptoms your student may experience. _____

Listed below is the procedure school personnel will follow in the event of an allergic reaction:

1. Observe student after allergen exposure.
2. Notify school nurse of allergen exposure.
3. Administer student's medication that has been ordered by the physician and has been provided by parent/guardian.
 Medication _____ Medication _____
 Dosage _____ Dosage _____
 Route _____ Route _____
4. If EPI-PEN Jr./EPI-PEN has been ordered and is administered, and/or if student experiences breathing difficulties 911 will be called.
5. Notify parent/guardian.

Please list any additional information or special information or special requests regarding above procedure for your child.

In case of serious illness and I cannot be reached, I authorize school personnel to contact:

Physician or clinic _____ Phone _____

Address _____ or transport by ambulance to _____.

Parent/Guardian Signature _____ Date _____

Building RN Signature _____ Date _____

Please note: A separate form for the administration of medication must also be included if medication is a part of the plan.

Medication & Physician order received: _____ Date _____