ALLERGY INFORMATION FORM AND ACTION PLAN

Student Name_____ Birth Date_____

Grade_____ Teacher_____

Emergency contact #(s) _____

Care Provider/Physician_____Phone_____

Please provide the following information:

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

Has your child had a life threatening allergic response in the past?

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)

****

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

_____ _____

Parent signature Date

FOR SCHOOL STAFF

Location of additional student Epipens: _____

Rev 08/2014