

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Severe Allergy to: \_\_\_\_\_  
 Reaction to the above: \_\_\_\_\_  
 Has student been hospitalized for this reaction: \_\_\_\_\_ If yes, date \_\_\_\_\_  
 Medications taken on a daily basis: \_\_\_\_\_  
 Are there diet restrictions? YES \_\_\_\_ NO \_\_\_\_

**DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS**

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**From the Infirmary Coordinator:** The "Severe Allergy Care Plan" is completed as a group effort and requires input from both the parent and the physician. Please note that this form does require a physician's signature. When I receive the completed form in my office, I will review it and share the information with your student's instructors.

**Reminder:** Faculty should carry EpiPen on all Field Trips. It should be kept at room temperature.

**Mild symptoms** of my student's allergy include the following: \_\_\_\_\_

Treatment for **mild symptoms** as listed above: \_\_\_\_\_

**Severe reactions may be life threatening and include:**

- Wheezing
- Swelling (face, neck)
- Tingling/swelling of tongue
- Vomiting
- Shock
- Loss of consciousness
- Other: \_\_\_\_\_

**Treatment for life threatening reaction including symptoms listed above:**

- EpiPen Jr. 0.15 mg
- EpiPen 0.3 MG

**1. Give immediately in outer thigh.**

- Pull off gray cap
- Place black tip against outer thigh and press hard until unit clicks.
- Hold in place 10 seconds, then withdraw.
- Dispose of in impermeable can or, give to emergency provider.

**2. Call 911 or, take student to the nearest Emergency Room.**

**3. Contact parent/guardian.**

**I authorize student to have access to EpiPen:**

Health Care Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_