

ALLERGY TREATMENT PLAN

Last Name:			
First Name:			
Grade	D.O.B		
Asthmatic: Yes*	No * Higher risk for severe reaction; please fill ou	t Asthma Form	
ALLERGIC TO:	If exposed to allergen and there are NO symptoms or mild localized symptoms:	If anaphylactic symptoms are shown*	
	☐ Epi-pen ☐ Epi-pen Jr ☐ Antihistamine Medication: Dose: Route:	EPIPEN / EPIPEN JR	
	☐ Epi-pen ☐ Epi-pen Jr ☐ Antihistamine Medication: Dose: Route:	EPIPEN / EPIPEN JR	
shown.	lergies can have severe reactions, and will be treated with an Epi ing, tingling, or swelling of lips, tongue, mouth; hives, itchy rash, swelli		
	ng, diarrhea; tightening of throat, hoarseness, hacking cough; shortnes		
EVEN IF PARENT/GUA OR TO TAKE CHILD TO	ARDIAN CANNOT BE REACHED, AUTHORIZATION D MEDICAL FACILITY!	IS GIVEN TO MEDICATE	
Parent/Guardian Signature	e Date		
Physician's Signature	Date		
Emergency Contact Information	, (including parents) in the order they should be called:		
Name	Phone Numbers Re	Numbers Relationship to child	

Students who have an allergy for which an Epi-pen is needed must have two clearly labeled Epi-pens stored in the school. Please check the expirations dates of all medication given in.