Allergy Action Plan and Individual Health Care Plan

*** This page is to be completed by the child's parent or guardian ***

Student Name: _____ DOB: _____

Life Threatening Allergy to: _____

Please initial when appropriate:

____ My child will carry his/her Epinephrine pen while at school.

____ My child knows how to self-administer his/her Epinephrine pen

____ My child will carry his/her own Epinephrine pen on the school bus to and from school.

____ I understand that a teacher or chaperone deemed qualified by the school nurse may administer the Epinephrine pen.

____ My child will carry his/her own Epinephrine pen on a field trip.

____ My child wears a medic alert bracelet.

____ I understand that the school nurse will share this information with school personnel.

____ I will provide a snack box for my child while in school.

____ I will retrieve the Epinephrine pen from the school on or before the last day of the school year.

____ I want my child to eat at a peanut/nut free table in the cafeteria and/or classroom.

Please note: your child is encouraged to invite a classmate to eat at his table with other food allergic students who have either brought their lunch from home or purchased a school lunch. However, for your child's safety, non-food allergic students must purchase a school lunch in order to sit at the peanut/nut free table.

Please note: For your child's safety, students with food allergies should ONLY consume foods and drinks provided by you and should not share food.

You are encouraged, if possible, to accompany your child as a chaperone on field trips.

Parent/ Guardian Signature: _____ Date: _____

FOR CLINIC USE ONLY

Epipen Location #1 _____ Expiration Date: _____

Epipen Location #2 _____ Expiration Date: _____

Epipen Location #3 _____ Expiration Date: _____