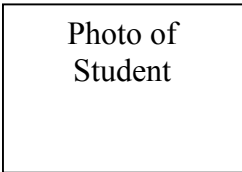


Davis Thayer Elementary School
Allergy Action Plan
Year _____



Dear Parent/Guardian,

Your child has been noted to have a **Life Threatening** allergy that could require emergency treatment while at school. In order to insure the best possible treatment plan please have your child's physician complete the bottom of this Allergy Action Plan. Parent/Guardian, please complete top **and** back of this form. If multiple **Life Threatening** allergies exist, please use one form for each allergy.

Date _____

Student _____ Grade _____ Teacher _____

Parent/Guardian _____ Phone # _____

Additional Emergency Contact _____ Phone # _____

Life Threatening Allergy to: _____

Age when first reaction occurred _____ Date of most recent reaction _____

Describe past reactions _____

To be Completed by Physician

MD's Name _____ Phone # _____
(Please print)

(Child's Name) _____ has a **Life Threatening** allergy to
_____ that may require emergency medical treatment
during the 2010-2011 school year.

Medication/Treatment Plan

Circle one: (for s/s anaphylaxis) EpiPen Jr. 0.15mg IM EpiPen 0.3mg IM

Additional Orders:

1. _____
2. _____
3. _____

Signature MD Date _____

***Parent/Guardian, please complete back side of this form.**

