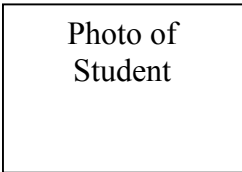


**Franklin High School**  
**Allergy Action Plan**  
Year \_\_\_\_\_



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.**

