EPINEPHRINE AUTO-INJECTOR – **SEVERE FOOD & INSECT ALLERGY (anaphylaxis)**

Please provide the school an allergy action plan initiated and signed by the physician

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Student Name: _____ DOB:_____ Grade:_____

Parent / Guardian name and phone number:_____

FOOD ALLERGY

To what food is the student allergic: _____

When was the student diagnosed: _____

Is the allergy caused by:_____ Ingestion (eating) _____Contact (touching) _____Proximity (being near)

Breakfast: _____at home _____ at school

Lunch: _____ bring lunch _____ school lunch

INSECT ALLERGY

To what insect is the student allergic: _____

When was the student diagnosed: _____

What symptoms does the student display when experiencing a severe allergic reaction?

- □ shortness of breath, wheezing or coughing
- □ skin color is pale or has a bluish color
- □ tight or hoarse throat
- □ trouble breathing or swallowing
- □ swelling of lips or tongue the bother breathing
- □ many hives or redness over body
- □ weak pulse
- □ fainting or dizziness
- □ vomiting or diarrhea (if severe or combined with other symptoms)
- □ feeling of doom, confusion, altered consciousness or agitation
- □ other: (please list)

Does the student wear an emergency medical bracelet? _____Yes _____No

Has the student ever been injected with epinephrine for a severe allergic reaction in the past? ____Yes ____No
If YES, when? _____

Has the student ever been hospitalized because of a severe allergic reaction: _____Yes _____ No
If YES, when?_____

Is the student aware of the allergy: ____Yes _____No

Can the student recognize their symptoms: _____Yes _____No

Can the student inject themselves with the epinephrine auto-injector: _____ Yes _____ No

Please list any other chronic medical conditions: _____

Please list any other medications the student takes at home: _____

Please list any drug allergies: _____

Pediatrician name and phone number: _____

Allergist name and phone number: _____

Which hospital do you prefer if your student needs to be transported by emergency services: _____

Are you or someone familiar with your child able to accompany the student on field trips in case they have an allergic reaction: _____ Yes _____ No

List any afterschool activities in which your student will participate during the school year:

Transportation:

Car Rider		Bus Rider	
_____AM	_____PM	_____AM bus #	_____PM bus #

****A student who has experienced or is at risk for life-threatening allergic reactions may carry an epinephrine auto-injector and self-administer epinephrine by auto-injector while in school, participating in school-sponsored activities, or in transit to or from school or school-sponsored activities if the school has been provided with parental and physician authorization.*