****ONLY FILL OUT IF YOUR CHILD HAS A FOOD OR BEE STING ALLERGY****

FOOD ALLERGY AND ANAPHYLAXIS CARE PLAN AND AUTHORIZATION FOR MEDICATION

TO BE COMPLETED BY PARENT:

Student's Name: _____ D.O.B: _____ Grade: _____

Parent/Caregiver: _____Phone (Cell): _____ Phone (W):_____

Emergency Contact: _____Relationship: _____ Phone: _____

Physician Managing Allergy: _____ Office Phone: _____

Allergies: (please indicate allergy and typical reaction when exposed)

- PEANUTS Reaction: _____
- TREE NUTS Reaction: _____
- EGGS Reaction: _____
- MILK Reaction: _____
  - Alternative to Milk Needed ___ YES ___ No If yes indicate type: _____
- GLUTEN Reaction: _____
- BEES Reaction: _____
- Other: _____ Reaction: _____

MEDICATIONS/DOSE

Epinephrine Brand or Generic: _____

Epinephrine Does: ☐ 0.1mg IM ☐ 0.15mg IM ☐ 0.3mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Bronchodilator Brand or Generic (Inhaler) if wheezing: _____

Bronchodilator Brand or Generic Dose: _____

_____ _____

Parent/Guardian Authorization Signature Date Physician Signature Date

FORM MUST COMPLETED AND SIGNED BY STUDENT'S PHYSICAN. ALL NEEDED MEDICATIONS MUST BE SUBMITTED TO THE SCHOOL, IN THE ORIGINAL PACKAGE, WITH PRESCRIPTION ATTACHED, TO THE OFFICE BY A CONSENTING ADULT PRIOR TO THE FIRST DAY OF SCHOOL.