ANAPHYLAXIS EMERGENCY PLAN

Student Name: _____ Birthdate: _____

Emergency Contacts/Telephone #: 1. _____

2. _____

3. _____

This student has a **life-threatening allergy** to the following:

_____

Strict avoidance of the allergen(s) by the student is critical to their well-being. An anaphylactic reaction can proceed quickly and prove fatal within minutes.

Epinephrine Auto-injector(s)

☐ **EpiPen Jr® 0.15mg**	☐ **EpiPen® 0.30mg**	**MedicAlert® Identification** ☐ **Yes** ☐ **No**
☐ **Twinject™ 0.15mg**	☐ **Twinject™ 0.30mg**	**Asthmatic** ☐ **Yes** ☐ **No**

Location(s) of Epipen: _____

PHYSICIAN

Name: _____ **Phone:** _____

PRE-AUTHORIZATION FOR THE ADMINSTRATION OF MEDICATION

I hereby pre-authorize and give permission for, _____

Name of School

to administer medication to my child in the event of an anaphylactic reaction, according to the Board's policies and procedures and the physician's prescription.

_____

Parent(s) Guardian(s) Signature **Date**

_____

Student's Signature **Date**