ANAPHYLAXIS STUDENT INFORMATION/RISK REDUCTION PLAN

Student Name:	Grade:

Does this student wear an allergy alert bracelet? Yes ☐ No ☐

Description of student allergy:
Foods/items which trigger an anaphylactic reaction:
Suggested monitoring and avoidance strategies:
Emergency procedure/treatment protocol if there is an anaphylactic reaction:
Provisions/information regarding storage for epinephrine auto-injectors (if necessary): _____ _____ Signature of Student's Physician Date

Emergency Contact Information

_____	_____
Print Name	Phone Number
_____	_____
Print Name	Phone Number

I give permission for the school to post and/or distribute photographs and medical information in key locations such as classrooms, school buses, staff rooms, etc. Yes ☐ No ☐

I give my consent for the school to assist with administration of medication via epinephrine auto-injector in the event of an emergency. Yes ☐ No ☐

I understand that it is my responsibility to ensure that this information regarding my child's anaphylactic allergy remains current and up-to-date and that I will notify the school if there are any changes. Yes ☐ No ☐

_____	_____
Signature of Parent(s)/Guardian(s)	Date
_____	_____
Signature of Principal	Date
_____	_____
Signature of Physician	Date

Information for all staff responsible for student

Location of auto-injector:_____

Names of those who can use auto-injector:_____

CHECKLIST:

- Training provided to all required staff, including volunteers
- Information made available in key locations
- Notify the transportation supervisor
- Review safety information with students