Allergy Record & Care Plan

_____

child name

Parent 1:	Emergency Contact Number(s):
Parent 2:	Emergency Contact Number(s):
Alternate Contact if Parents Unreachable:	Emergency Contact Number(s):
Physician Name:	Physician Telephone:

Child's known allergens. Please list:

Are there any accommodations which the school or classroom must provide for this child to avoid having an allergic reaction?

Child's symptoms during an allergic reaction? Please describe and/or list:

School Treatment Plan If Allergic Reaction Suspected (i.e. Epi Pen, Benadryl, etc.).
Please attach physician's action plan if available.

Does child require an Epi-pen for treatment of severe allergic reactions? □Yes □No

If so, please provide the school with an Epi-pen in case of emergency.
This Epi-pen must include the label from the pharmacy.

Confirmation of Medication Name & Dosage If Applicable	
Medication Name	Dosage

PERMISSION TO ADMINISTER MEDICATION

I, _____, parent/guardian of _____
Parent/Guardian's Name Child's Name

give permission to the Shadyside Presbyterian Church Nursery School to administer

_____ to my child in case of a severe allergic reaction.
Medication name and dosage

I have provided the school with the medication, clearly labeled with my child's name, dosage and mode of administration. I have given written detailed instructions on when and how to administer the medication to my child. I understand that this medication will only be administered in an emergency. I will be responsible for collecting the medication at the close of the school year and understand that it will be discarded if not collected.

_____ Date_____
Parent signature