Severe Allergy Action Plan and Authorization Letter

Date: [Insert Date]

To: [Name of School/Organization/Childcare Provider]

1. Student/Participant Information

Name: [Full Name]
Date of Birth: [Date of Birth]
Allergy To: [List specific allergens, e.g., Peanuts, Bee Stings, Latex]

2. Emergency Contact Information

Parent/Guardian 1: [Name] - [Phone Number]
Parent/Guardian 2: [Name] - [Phone Number]
Physician Name: [Doctor Name] - [Doctor Phone Number]

3. Signs of an Allergic Reaction

- **Mild Symptoms:** Hives, itchy mouth, mild stomach ache.
- **Severe Symptoms (Anaphylaxis):** Swelling of the tongue/throat, difficulty breathing, wheezing, weak pulse, fainting, pale/blue skin color.

4. Action Plan

For Mild Symptoms: [Insert Instructions, e.g., Give Antihistamine and monitor]
For Severe Symptoms: [Insert Instructions, e.g., Administer Epinephrine Auto-Injector immediately and call 911]

5. Medication Authorization

I, [Parent/Guardian Name], hereby authorize the staff of [Name of Organization] to administer the following medication(s) to my child in the event of an allergic reaction:

- **Epinephrine Brand/Dosage:** [e.g., EpiPen Jr. 0.15mg]
- **Antihistamine Brand/Dosage:** [e.g., Benadryl 25mg]
- **Storage Location:** [e.g., Backpack / Nurse's Office]

6. Consent and Signature

I give permission for the staff to take appropriate emergency measures and to share this information with relevant personnel. I understand that 911 will be called any time Epinephrine is administered.

Parent/Guardian Signature: _____ Date: _____

Physician Signature (if required): _____ Date: _____