



Date:

RE:

DOB:

Dear Health Care Provider:

The above student has been identified as having severe allergies. Please complete the attached *Allergy Action Plan*.

This form has two purposes:

- It is the **medication authorization** for any medications you prescribe to be used at school in the event of an allergic reaction.
- It is the **emergency health care plan** that will be used by non-licensed school staff who are trained by the school nurse to administer epi-pens and other medications.

Thank you for your prompt response.

Sincerely,

School Nurse

Form 3666 (5/04)

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