IMMANUEL LUTHERAN
CHURCH | SCHOOL | PRESCHOOL

Please attach a small photo of the child here

Allergy and/or Medical Action Plan

School Year_____

Child's Name: _____ Date of Birth: _____ Child's Weight: _____

Emergency Contacts:

Physician's Name: _____ Phone Number: _____

Mother's Name: _____ Phone Number: _____

Father's Name: _____ Phone Number: _____

Please complete the appropriate box(es) below:

☐ My child has been diagnosed with the following **allergies**: _____

_____

Symptoms of exposure: _____

_____

_____

Action to be taken if my child shows these symptoms:

1. _____
2. _____
3. _____

☐ My child has been diagnosed with the following **medical condition**: _____

_____

Symptoms: _____

_____

_____

Action to be taken if child shows these symptoms:

1. _____
2. _____
3. _____

Is epi-pen or other medication to be given? ☐ Yes ☐ No

Name of Medication: _____ Dosage: _____

Name of Medication: _____ Dosage: _____

***Physician Signature**: _____ Date: _____

Physician's Signature is needed only if epi-pen or other medication is to be kept and/or dispensed at school.

I give permission to the preschool staff to give the above medication to my child. I am aware that it is my responsibility to provide medication and epi-pens in the original packaging, including my child's name and dosing instructions. I am aware of the expiration date and will replace epi-pens or medication before the expiration date.

Parent Signature: _____ Date: _____