

## ALLERGIC REACTION TO FOODS/INSECT BITES/OTHER

**Allergic to:** \_\_\_\_\_

Student's Name: \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Dr.'s Name \_\_\_\_\_ Phone \_\_\_\_\_

What are the signs of actual reaction? (i.e. Local swelling, respiratory difficulty)

Explain: \_\_\_\_\_

\_\_\_\_\_

Does student recognize when he/she is having a reaction? (circle) **Yes**      **No**

School Management of allergic reaction-be specific: \_\_\_\_\_

\_\_\_\_\_

If medication is needed, please name: \_\_\_\_\_

Epi-Pen? **Yes** **No**      Self-Inject? **Yes** **No**      Needs Help? **Yes** **No**

At what point do you want the school to contact you? \_\_\_\_\_

If child continues in distress, what action do you advise the health office to take? \_\_\_\_\_

\_\_\_\_\_

Is there anything else you would like to add about this child's reaction? \_\_\_\_\_

I release the school personnel from liability in the event of any reaction that results from the medication.

I give permission for the LSN/RN/HEA to consult/communicate with the above named student's physician/licensed prescriber and pertinent school personnel regarding my student's health condition, medication action and side effects.

I give permission to delegate schools personnel to administer medication on field trips.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

---