Severe Allergy/Anaphylaxis History Form

for _____ School Year

Student Name: _____ Date of Birth: _____ Gender: M / F Grade____

Parent Contact: _____ Ph. Number: _____(home) _____(work/cell)

- ☐ My child's allergies are **VERY MILD** and require **NO MEDICATION, TREATMENT, AND/OR EMERGENCY CARE PLAN AT SCHOOL**
- ☐ My child's allergies are **SIGNIFICANT** and may require **MEDICATION, TREATMENT, AND/OR EMERGENCY CARE PLAN AT SCHOOL.**
- ☐ My child's allergies are diagnosed as **LIFE-THREATENING and require MEDICATION< TREATMENT AND EMERGEMNCY CARE PLAN AT SCHOOL.** (Care plans are required by state law, for students with Life-Threatening allergies)

****IF YOUR CHILD NEEDS AN EMERGENCY CARE PLAN ON FILE AT SCHOOL, PLEASE FILL OUT THE FOLLOWING:**

Allergy: _____ ☐Mild-Moderate ☐Severe ☐Life-Threatening

Usual Symptoms: _____

How quickly do the signs and symptoms appear after exposure?
____ Seconds ____ Minutes ____Hours ____Days

What has to happen for your child to react to the Allery?
☐Eating foods ☐Touching Foods ☐Smelling Foods ☐Bite/Sting ☐Other, explain:
_____

Has your child been tested for this allergy by an allergy specialist ☐Yes ☐No

Allergan's Name: _____ Phone: _____

If bee sting allergy, what kind of bee(s)? _____

Does your child have Asthma? ☐ Yes ☐No
Is your child allergic to any medications? ☐ Yes ☐No
If yes, please list: _____
Other Allergies: _____

Medications needed at school for this allergy:
☐ Benadryl
☐ Epi-Pen
☐ Inhaler
☐ Other: _____

Comments: _____
_____

Parent/Guardians Signature: _____ Date: _____

Review by R.N. _____ Date: _____