NAME: _____

(**Fill out this form only if your child has been diagnosed with an allergy**)

Date of Birth_____ Grade_____ Teacher_____

ALLERGIC TO: _____ Asthmatic? Yes* No

*Higher risk for severe reaction

Details of Allergy

(If dairy, is it all or only some dairy products? I f environmental, is it seasonal or specific to particular agents? If insect bites, is it all insects or specific ones? Please specify.)

_____

_____

Signs of an Allergic Reaction

(What kind of reaction has the child had in the past? Please circle or underline those that apply.)

EYES Itching and redness, puffiness or swelling around the eyes

MOUTH Itching and swelling of the lips, tongue, or mouth

THROAT Itching or sense of tightness in the throat, hoarseness, hacking cough

SKIN hives, rash, swelling about the face or extremities

GUT nausea, abdominal cramps, vomiting, diarrhea

LUNG shortness of breath, repetitive coughing, wheezing

HEART "thready" pulse, passing out

OTHER: _____

Action to be Taken

(What would you like us to do if the child is exposed to a known allergen?)

Emergency Medical Services

_____ Call 911 immediately

_____ Call parent first. Call 911 only if symptoms are severe or do not improve with medication.

Medications

_____Give _____immediately.
Medication, Dosage

_____ Give _____only for the following symptoms:

_____

Parent Signature _____Date _____