



ALLERGY ASSESSMENT and CARE PLAN

If your child requires any medication in the event of an allergic reaction, the school must have a “Medication Authorization Form” on file, signed by both physician and parent.

A new medication form is due each school year. Students are permitted to carry EPI-PENs with the proper documentation in the health office.

School Year: ____/____

Student: _____ Birthdate: _____ Grade: _____

Parent/guardian name _____ Home Phone: _____

Address: _____ Cell Phone: _____

Parent/guardian name _____ Home Phone: _____

Address: _____ Cell Phone: _____

In the event we are unable to reach you:

Emergency phone contact: _____

(other than parent) name relationship phone

List your child’s allergies: _____

Date of your child’s last significant allergic reaction: _____

Please circle any symptoms that apply to your child’s allergic reaction:

- | | | | |
|---------------------------|-------------------------------|--------------------------------|------------------------|
| Feeling of apprehension | Feeling of fullness in throat | Tingling sensation mouth/face | Itching |
| Weakness | Sweating | Change in voice quality | Respiratory difficulty |
| Hives | Low blood pressure | Rapid pulse | Rash |
| Wheezing | Nasal congestion | Localized redness and swelling | |
| Other (be specific) _____ | | | |

Check medication your child requires in the event of an allergic reaction:

_____ Benadryl _____ EPI-PEN Other _____

Does your child carry an EPI-PEN at all times? _____ Yes _____ No

Where is (are) EPI-PEN (s) kept for student? _____

Has student been instructed in: _____ Signs/symptoms of significant allergic reaction?

_____ Use of EPI-PEN

Does your child wear a “Medic Alert” bracelet? _____ Yes _____ No

EMERGENCY PLAN (Complete with input from your physician)

List below a step by step plan for your child in the event he/she has an allergic reaction at school:

- _____
- _____
- _____

Additional comments: _____

Name of physician: _____ Physician’s signature: _____

May the school nurse contact the physician in case there are any questions or concerns in making an emergency plan for your child? _____ Yes _____ No

Parent/Guardian Signature: _____ Date: _____

Reviewed by (school nurse): _____ Date: _____