ALLERGY INFORMATION FORM

Student's Full Name: ____ Date of Birth: _______________________

Please choose one:

❏ My child does not have a life threatening anaphylactic reaction allergy. Please sign and return this form to the school office.

Parent/Guardian Signature: ____ Date: ______________________

❏ My child has a life threatening anaphylactic reaction allergy. Please sign and continue filling out the information below, and return to school office.

Parent/Guardian Signature: ____ Date: ______________________

1. Check the items that have caused an allergic reaction: __Peanuts/Peanut products __Fish/Shellfish __Eggs

   __Tree Nuts (walnuts, almonds, etc.) __Bee Stings __Soy Products __Milk __Tree Nut products (butters/oils, etc.)

2. Please list any others: ____
3. How many times has your child had a reaction? __Never __Once __more than once

   Please describe: ____

4. When was the last reaction? ____
5. What are the signs and symptoms of your child's allergic reaction? (Please be specific: include things the child might say).

   ____

6. Does your child have asthma? __Yes __No
7. Has your child ever needed treatment at a clinic or hospital for an allergic reaction? __Yes __No

   If yes, please explain: ____

8. Has your child ever received or used an Epi-Pen or other injection as treatment? __Yes __No

   If yes, please explain: ____

9. Does your child understand how to avoid allergens? __Yes __No

10. What do you do at home if there is an allergic reaction? ____

11. What treatment or medication has your health care provider recommended for an allergic reaction?

    Please be specific: ____

PLEASE NOTE: A completely filled and signed Medication Authorization Form must be provided if medications are required during school hours.