Public Health
Prevent. Promote. Protect.

Board of Health
Sidney-Shelby County

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ALLERGY/ANAPHYLACTICE REACTION HISTORY

To the Parents/Guardians of: _____ Age: _____ Grade: ___ Teacher: _____

According to our records you have informed the school that your child has a history of allergic/anaphylactic reactions. Please complete the information below. This will help school staff members know more about how your child and his/her medical condition and the best way to protect the health and safety of your child while at school.

Please return this form to the public health/school nurse to add to your child's confidential health record. The nurse will inform all appropriate school staff members regarding this information.

Check any life-threatening allergy this student has:

__ Insect stings List type _____
__ Animals List type _____
__ Food List type _____
__ Other List type _____

Indicate the signs that are usually present during an allergy attack:

__Difficulty breathing
__Rash
__Nausea
__Flushed skin
__Very pale skin
__Loss of consciousness
__Difficulty swallowing
__Other_____
__Swelling / where? _____
how much? _____

Has emergency medical treatment been needed in the past year for allergies? __No __Yes When?_____

Does student have an EPI Pen? _____ Yes _____ No

If you plan to have medication available at school, medication forms must be completed and signed by you and your doctor (your physician MUST complete the request for medication administration). This form is required by the school nurse before any medication can be given at school.

If a bee or wasp sting occurs at school, your child will be given basic first aid. You will be notified. If necessary, your child will be transported by rescue squad to the nearest hospital as designated on the student's emergency medical form.

Thank you for your cooperation. Please contact the public health nurse/school nurse if you have any questions.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Physician's Name Physicians Telephone Number

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