For recognition purposes in case of emergency, please attach a recent photo of your child to this form.

ALLERGY PROTOCOL

Student's Name: _____ Grade: _____
ALLERGIC TO: _____
ASTHMATIC: Yes____ (Please fill out the Asthma Action Form) No_____

SIGNS OF AN ALLERGIC REACTION INCLUDE:
Please circle anticipated symptoms:
* High risk for severe reaction

Systems:	**Symptoms:**
MOUTH	**itching and swelling of the lips, tongue, or mouth**
THROAT*	**itching and/or a sense of tightness in the throat, hoarseness and hacking cough**
SKIN	**hives, itchy rash, and/or swelling about the face or extremities**
GI	**nausea, abdominal cramps, vomiting and/or diarrhea**
LUNG*	**shortness of breath, repetitive coughing and/or wheezing**
HEART*	**"thready" pulse, "passing-out"**
OTHER	_____

All above symptoms can potentially progress to a life-threatening situation!

ACTION: If **ingestion is suspected** notify the School Nurse immediately!

1. If **severe reaction** is observed, immediately give

_____ _____ _____
Medication Dosage Route

If **no or mild reaction** is observed, immediately give

_____ _____ _____
Medication Dosage Route

2. **Call 911**
3. **NOTIFY EMERGENCY CONTACTS**:

Mother Phone (H) _____ (W) _____ Cell_____

Father Phone (H)_____ (W)_____ Cell_____

Please be aware that when a Nurse is not in attendance on school trips, this plan will not be followed, except for Epi-pen administration. Antihistamines and inhalers will not be administered. If you desire to have your child self-administer any medications, please complete the self-administration form and return it to the Health Office.

_____
Parent Name

_____
Parent Signature

Date: _____/_____/_____

_____
Physician's Name and Phone Number

_____
Physician's Signature

Date: _____/_____/_____