# Allergy Form
# Arizona Autism Charter Schools (AZACS)

**Student Name**:_____

**Allergies to**:_____
**Medical documentation may be requested*

**Asthma (Circle)**: Yes* or No
(*High Risk for severe reaction)

**SIGNS OF AN ALLERGIC REACTION:**

| System | Symptoms | Note all that apply |
|---|---|---|
| Mouth | Itching & swelling of the lips, tongue, or mouth | |
| Throat | Tightness, Coughing, Itchy | |
| Skin | Rash, and/or swelling about the face or extremities | |
| Gut | Nausea, abdominal cramps, vomiting, and/or diarrhea | |
| Lung | Shortness of breath, repetitive coughing, and/or wheezing | |
| Heart | Thready pulse, passing-out | |

**Action for minor reaction:**

If symptom(s) are:_____
(Check steps that apply)

- ❑ Administer:_____ medication/dose/route
- ❑ Then call: Parent/Guardian
- ❑ Health Care Provider

If condition does not improve within 10 minutes, follow steps for Severe Reaction below:

**Action for severe reaction:**

If symptom(s) are:_____
(Check steps that apply)

- ❑ Administer:_____IMMEDIATELY medication/dose/route
- ❑ Call: Parent or Guardian
- ❑ Call: 911 (Never hesitate to call 911)

_____

**Signature of Parent/Guardian** **Date**