Mounds View PUBLIC SCHOOLS

Severe/Life Threatening Allergy Information Form
To be completed by parent/guardian

Please complete this form and return to the Licensed School Nurse _____ Phone# _____
The following information is helpful in planning for the safety of your child at school.

Student's Name _____Date of Birth _____Grade _____

Information provided by _____
Name Relationship Date

PLEASE NOTE PARENT/OTHER EMERGENCY CONTACT #'S IN PREFERRED CONTACT ORDER:

NAME	RELATIONSHIP	PHONE #	H	W	C

Licensed Health Care Provider _____ Clinic _____

Phone # _____ Fax # _____ Hospital Preference _____

Has your child been diagnosed with allergies/anaphylactic reaction by a health care provider? ❑ YES ❑ NO

Health Care Provider making diagnosis _____ Date _____

Does your child have asthma? ❑ YES ❑ NO If yes, please list all current asthma medications in box on next page.

Please ✓ what usually triggers (starts) your child's allergy attack/episode:

❑ peanuts ❑ tree nuts ❑ insect stings (kind: _____)
❑ seafood ❑ eggs ❑ animal (list: _____)
❑ latex ❑ soy ❑ medications (list: _____)
❑ fish ❑ dairy products (list: _____)
❑ other: _____

Please ✓ what your child does to prevent or avoid an allergic reaction:

❑ knows what to avoid (list: _____)
❑ tells other people about his/her allergies
❑ tells an adult **immediately** if exposed to an allergen (e.g. stung by a bee, ate a peanut, latex exposure etc.)
❑ wears a medical alert bracelet or necklace
❑ asks about ingredients in food, if unsure about contents
❑ firmly refuses food that might contain a problem food
❑ avoids contact with animals
❑ other: _____

How soon after contact does your child react? (minutes/hours/days) _____

How often has your child been treated for an allergic reaction by a health care provider? _____

When was the last time that your child was treated for an allergic reaction? _____

What are the early-warning signs (physical and/or emotional changes) that indicate your child is starting to have an allergic reaction? _____

Does she/he recognize these signs/symptoms? ❑ YES ❑ NO

Skin Hives, itching, rash, flushing, swelling of face or extremities

Mouth Itching, swelling of lips, tongue, or mouth

Throat *Itching, sense of tightness in throat, hoarseness, hacking cough

Lung *Shortness of breath, repetitive coughing, wheezing

Heart * "Thready" pulse, "passing out"

Gut Nausea, abdominal cramps, vomiting, diarrhea

Other _____

Please circle or underline the specific symptoms of allergic reaction listed on the left experienced by your child in the past.

* Potentially life-threatening symptoms
All Symptoms can become life threatening

Does your child know how to avoid causes of allergic reactions? ❑ YES ❑ NO

Please list all medications prescribed by a licensed health care provider to treat your child's allergies and asthma: (e.g. Benadryl, EpiPen, Flovent, Singulair, Albuterol)

MEDICATION NAME	BY (mouth or shot)	DOSE	TIMES PER DAY	WHEN IS IT TAKEN ?

If a medication is to be given at school, a Medication Authorization Form must be completed yearly or **if changes are needed**. The licensed school nurse in consultation with the licensed health care provider and parent/guardian may authorize self-administration if the student is deemed capable. Medication must be in the original labeled container.

If your child has an EpiPen prescribed:

- Has she/he received training on how to self-administer? ❑ YES ❑ NO
- Has she/he ever self-administered? ❑ YES, when _____ ❑ NO

An EpiPen may be given by designated persons trained by the licensed school nurse

Please add anything else that you would like school personnel to know about your child's allergies.

- I authorize release/sharing of information related to allergies between the school nurse and the health care provider to plan and coordinate care during school.
- This information will be shared with necessary school personnel in order to take care of your child at school.

_____ _____ _____

Parent/Guardian signature Date Phone Number