Mounds View PUBLIC SCHOOLS

Severe/Life Threatening Allergy Information Form

To be completed by parent/guardian

The following information will help us learn a little more about your child's allergy and plan for the safety of your child at school. **Please complete this form and return to the Health Office.**

Student's Name _____Date of Birth _____Grade _____

Information provided by _____
Name Relationship Date

Please ✔ what your child is allergic to:

❑ peanuts	❑ tree nuts	❑ insect stings (kind: _____)
❑ shellfish/seafood	❑ eggs	❑ animal (list: _____)
❑ latex	❑ soy	❑ medications (list: _____)
❑ fish	❑ wheat	❑ 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
❑ needs special seating arrangements in the cafeteria
❑ does not need special seating arrangements in the cafeteria
❑ other: _____

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? _____
Are there 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
Is there anything else you would like us to know about your child's allergy? _____
_____

An Anaphylaxis Action/Emergency Plan 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.

- 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