Solen Public School

RECORD OF MILD ALLERGIES

Child's Name:_____ Date of Birth:_____ Grade:_____

Allergy/Allergies to: _____

Date of First Reaction: _____ Date of Most Recent Reaction:_____

Symptoms:_____

How was the most recent reaction treated? _____

_____

Is the child asthmatic? ☐ Yes ☐ No

Please check all symptoms the child has experienced:

Mouth:
- ☐ Itching of lips
- ☐ Itching of tongue
- ☐ Itching of mouth
- ☐ Swelling of lips
- ☐ Swelling of tongue
- ☐ Swelling of mouth

Throat:
- ☐ Itching in throat
- ☐ Sense of tightness in throat
- ☐ Hoarseness
- ☐ Hacking/coughing

Heart:
- ☐ "Thready" pulse
- ☐ Passing out

Skin:
- ☐ Hives
- ☐ Itchy rash
- ☐ Swelling around the face
- ☐ Swelling around arms
- ☐ Swelling around legs

Gut:
- ☐ Nausea
- ☐ Abdominal Cramps
- ☐ Vomiting
- ☐ Diarrhea

Lung:
- ☐ Shortness of breath
- ☐ Repetitive coughing
- ☐ Wheezing

ACTION:
If exposed to the allergen is suspected,

1. Administer: (Medication)_____
   (Dose)_____ (Route)_____
2. and (any other actions)_____.

If signs of anaphylaxis develop (great difficulty in breathing or swallowing, hives, numbness or "cottony" feeling or "pins & needles" feeling in the mouth, severe chest pain, convulsions, extreme weakness with paleness and collapse, vomiting), **transport to** _____**Hospital** or transport to closest hospital if on field trip or off school property.

If the student requires Benadryl, Epinephrine via Epi-Pen, or other over the counter medication complete form AM-2 Request for Administration of Prescription Medication.

Parent/Guardian Signature:_____ Date:_____

In signing this you authorize the school administrator to direct members of the school staff to assist the student in taking the above listed medications and agree that you will not hold liable, any member of the school staff or an individual of official capacity who is directed by you and the school administrator to assist the student in taking said medications