Solen Public School

RECORD OF SEVERE ALLERGIES

Page 1 to be completed by parent/guardian in clear printing for all students with allergies. **Page 2** to be completed by physician for students requiring medications; parent/guardian to sign bottom portion.

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, give (Medication)_____
(Dose)_____ (Route)_____ 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.** (Will transport to closest hospital if on field trip or off school property).

Epinephrine via Epi-Pen will be given according to physician medication instructions.

Please have your child's physician complete and sign a physician's request for administration of medication for each prescription medication. Use additional sheets if necessary. This information will be shared with your child's teachers, transportation personnel (bus drivers), and school staff as appropriate.

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.

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MEDICATION REQUEST FOR SEVERE ALLERGIES

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION FOR EXPOSURE TO ALLERGEN: _____

Child's Name: _____ Age: _____ Grade: _____

Diagnosis: _____. In the event of exposure, please initiate treatment in the following order.

Immediate treatment: _____

If symptoms progress to: _____ (please list and describe), _____ insitiute the following treatment plan: _____

Please complete the following for any medications listed in the above plan.

Medication	Medication
Dose	Dose
Route	Route
Time	Time
Rx# Pharmacy	Rx# Pharmacy
Side Effects	Side Effects

Duration: ☐ School year _____ ☐ other _____

Remarks _____

Physician's Signature _____ Date: _____

Printed Name _____ Phone # _____

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.

_____ _____

Parent/Guardian Signature Date