Allergy Reference Form

TO BE COMPLETED BY STUDENT'S PHYSICIAN

Student Name_____Birthdate_____

Allergic to:_____

Previous reactions caused by (circle all that apply) **INGESTION, AIRBORNE EXPOSURE, SKIN CONTACT**

Previous reaction **SYMPTOMS** noted: _____

(Note each allergic reaction can be different and all can progress to life threatening)

The student: _____is **NOT AT HIGH RISK**
_____ is at **HIGH RISK** for experiencing an Anaphylactic/Life Threatening Reaction **due to**:

_____Previous anaphylactic reaction requiring EMS and Medication (Date of last reaction_____)
_____Diagnosed with Asthma (Higher risk for severe reaction)
_____Previous local allergic reaction ONLY (Medication prescribed in case of severe reaction in future)
_____Other:_____

IF Student requires medication to be available physician MUST complete Allergy Action Plan ➡

Student's condition **requires** medications to be available in the following locations at School
(circle/check **all** that apply)

❑ Self Carry (on person / backpack) Permission to Carry Form **REQUIRED**	Epinephrine	Antihistamine
❑ Classroom	Epinephrine	Antihistamine
❑ Cafeteria	Epinephrine	Antihistamine
❑ Before / After School	Epinephrine	Antihistamine
❑ Extracurricular Activity	Epinephrine	Antihistamine
❑ School Bus	Epinephrine	Antihistamine
❑ Playground/Field/Outdoor	Epinephrine	Antihistamine
❑ OTHER_____	Epinephrine	Antihistamine

*EXPIRED Medication can NOT be administered.

Student requires a ALLERGY IDENTIFICATION BRACELET be worn at school : ❑ Yes ❑ No

Physician discussed the following with Parent and Student

- ❑ Avoidance of allergen _____
- ❑ How to Read Food Labels for allergen
- ❑ Report Bullying to School principal
- ❑ Safe Emergency Medication storage/use
- ❑ Use of auto-inject device
- ❑ Emergency response to allergen reviewed
- ❑ Actions to take IF exposed to allergen
- ❑ Allergen Cross contamination risks/preventions
- ❑ Medication expiration dates
- ❑ Emergency Medication refill procedure
- ❑ Signs/Symptoms of allergic reaction
- ❑ Other_____

_____ _____

Physician Signature Date Parent/Guardian Signature Date