

CHILDREN'S/AISD STUDENT HEALTH SERVICES

Anaphylaxis/Allergic Reaction Information from Parent

Student's name _____ D.O.B. _____ School _____ Teacher/grade _____

Parent/Guardian _____ Phone(H) _____ Phone(W) _____ Phone(Cell) _____

Parent/Guardian _____ Phone(H) _____ Phone(W) _____ Phone(Cell) _____

Emergency contact _____ Relationship _____ Phone _____

Physician/Clinic _____ Phone(office) _____ FAX _____

Does your child see another doctor/clinic for anaphylaxis/allergic reaction? (If yes, please complete doctor information)? Yes No

Doctor/Clinic _____ Phone(office) _____ FAX _____

List all medications: Home _____

School _____

What date did you child have their first anaphylactic/allergic reaction? _____

How many anaphylactic/allergic reactions has your child had since the first reaction? _____

When was your child's last anaphylactic/allergic reaction? _____

Has your child been hospitalized due to an allergic/anaphylaxis reaction? Yes No

Does your child have an Epi-pen? Yes No

Does your child have asthma? Yes No

What triggers an anaphylaxis/allergic reaction in your child? (Check all that apply)

- Bee/Wasp sting
- Ant Bite
- Other Insect Sting _____
- Peanuts
- Tree Nuts
- Other Nuts _____
- Wheat
- Soy
- Milk
- Eggs
- Fish
- Shellfish
- Other Foods _____
- Other Foods _____
- Other Foods _____
- Plants, flowers, cut grass, pollen
- Other _____
- Other _____
- Other: _____

Describe the symptoms your child experiences before or during an anaphylaxis/allergic reaction. (Check all that apply)

- Hives
- Difficulty Breathing
- Paleness
- Complaint of tingling, itchiness, or metallic taste in the mouth
- Vomiting
- Cramps/Stomach Pain
- Diarrhea
- Swelling/itching of the mouth or throat area
- Loss of consciousness
- Other _____
- Other _____
- Other _____

Authorization for Release of Medical Information:

1. **I hereby authorize** _____ Doctor/Clinic/ to furnish anaphylaxis/allergic reaction related information regarding my child _____ Student's Name to the Student Health Services personnel at _____ school.

Parent/Guardian Signature

Print Name

Date

2. **I give permission** for the school nurse to communicate with my child's doctor concerning their anaphylaxis/allergic reaction and its treatment

Parent/Guardian Signature

Print Name

Date