ALLERGY PLAN

Child's Name_____ Birth Date _____

Description of Allergy: _____

Specific Triggers: _____

Avoidance Techniques: _____

Select symptoms that may be experienced when exposed to allergen:
(may occur right away or much later after contact with the allergen)

- ☐ No history of symptoms or unknown
- ☐ Mouth: Itching; tingling; swelling of lips; tongue or mouth ("mouth feels funny")
- ☐ Skin: Hives; itchy rash; swelling of the face or extremities
- ☐ Gut: Nausea; abdominal cramps; vomiting; diarrhea
- ☐ Throat: Difficulty swallowing; hoarseness; hacking cough
- ☐ Lungs: Shortness of breath; repetitive coughing; wheezing
- ☐ Heart: Weak or fast pulse; low blood pressure; fainting; pale; blueness
- ☐ Other: _____

If needed, please list any additional information regarding symptoms:

_____

Treatment:

1.Immediately give _____

_____

_____

2. Call 911

3. Call parents at these #'s: _____

Doctor #: _____ Hospital #: _____

Can we post your child's name, allergies & medication location in the classroom? ___yes ___no
If no, we will cover the allergy information with another sheet of paper.

By signing below, the parent/guardian permits staff to administer medications or call 911 even if parent/guardian or doctor cannot be reached.

_____ _____ _____

Signature of Parent/Guardian Relationship to Child Date

MEDICATION FORM

Consent for administration of medication during the school day.

Parents of students requesting that medication be administered during school hours by school staff are required to provide for the school:
1. A statement from the physician.
2. A parental release for the administration of medication.

Child's Name_____ Birth Date _____

Home Address _____

Physician's order for administration of medication by school staff.

Medication_____

Dosage and time of administration_____

Possible side effects _____

Purpose or condition for which prescribed _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Office Address Physician's Phone #

Parental Release for the administration of medication

I request this medication be given as prescribed and the above information be released to the physician as requested.
I release school staff from any liability concerning the administration of this medication at school.
I understand I must provide this medication in the **original, properly labeled pharmacy container.**

_____ _____ _____
Signature of Parent/Guardian Relationship to Child Date

Medication Record

Child's Name:_____ Birth Date: _____

Medication & Dosage: _____

Dates & times to be administered: _____

Refrigeration? _____yes _____no

_____	_____	_____
Signature of Parent/Guardian	Relationship to Child	Date

Record of medication given during school hours:

Date	Administered By	Time	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____