

NOTICE OF ALLERGY

Child's Name: _____ Grade _____

Allergy to: _____ (list one allergy per form)

Is the child asthmatic? YES NO

ACTION

1. If ingestion/sting/reaction is suspected/known, give _____
(medication/dose/route
and _____ immediately!

2. Call 911

3. Call Mother: _____ Call Father: _____
alt # _____ alt # _____

or call emergency contacts listed below.

4. Call Dr. _____ at _____
Phone # _____

Emergency Contacts:

1. _____ Relation: _____ Phone: _____
2. _____ Relation: _____ Phone: _____

Parent's Signature and date: _____/_____

DOCTOR'S RECOMMENDATIONS (To be completed by physician **ONLY**):

Is this allergy (circle all that apply) airborne/ ingested / per instance (stings, bites, etc.)

Symptoms: (please check all that could apply)

| | |
|--------------|--|
| ____ Mouth | itching & swelling of the lips, tongue, or mouth |
| ____ Throat | itching and or a sense of tightness in the throat, hoarseness, cough |
| ____ Skin | hives, itchy rash, and or swelling about the face or extremities |
| ____ Abdomen | nausea, abdominal cramps, vomiting, and or diarrhea |
| ____ Lung | shortness of breath, repetitive coughing, and or wheezing |
| ____ Heart | “thready” pulse, passing out |

Doctor's Signature and date: _____/_____