TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM

FOOD/INSECT ALLERGY

Please complete the following information specific to your child's needs and return it to the School Nurse.

Child's Name:__________________________________DOB:_____________________ Grade_________

Physicians' Name:_______________________________Telephone :___________________________

Child's Health Problems:____

Asthma: Yes_____ No____ **SEAT CHILD AT THE NUT FREE TABLE Yes ____ No ____**

Please provide information describing your child's allergy to each food, insect, or other allergen. Be as specific as possible.

Food/Insect____

Check signs usually present during attack:

____difficulty breathing
____wheezing or coughing
____difficulty swallowing
____swelling
-where?_____________
____dizziness
____loss of consciousness
____flushed or pale
____nausea, vomiting
____cramps, or diarrhea
____itching
-where?_____________
____rash or hives
-where?_____________

Food/Insect____

Check signs usually present during attack:

____difficulty breathing
____wheezing or coughing
____difficulty swallowing
____swelling
-where?_____________
____dizziness
____loss of consciousness
____flushed or pale
____nausea, vomiting
____cramps, or diarrhea
____itching
-where?_____________
____rash or hives
-where?_____________

Food/Insect____

Check signs usually present during attack:

____difficulty breathing
____wheezing or coughing
____difficulty swallowing
____swelling
-where?____________
____dizziness
____loss of consciousness
____flushed or pale
____nausea, vomiting
____cramps, or diarrhea
____itching
-where?____________
____rash or hives
-where?____________

PLEASE CONTINUE ON OTHER SIDE

TOWN OF FAIRFIELD SCHOOL HEALTH PROGRAM
FOOD/INSECT ALLERGY (cont.)
2.

Food/Insect____

Check signs usually present during attack:

____difficulty breathing	____flushed or pale
____wheezing or coughing	____nausea, vomiting
____difficulty swallowing	____cramps, or diarrhea
____swelling	____itching
-where?____________	-where?____________
____dizziness	____rash or hives
____loss of consciousness	-where?____________

Has hospitalization or other medical treatment been needed in the past for allergies?

yes____ no____

When?____

If yes, please describe:____

____

Preferred Hospital:____

Has medication been needed in the past for allergies?

Yes____ no____

List measures needed at school to help prevent a severe allergic reaction:
____

____

If food allergy, how have lunch and snacks been handled in the past?_________________________

____

____

Please have attached medication authorization form filled out by child's physician and parent. Return the authorization to school immediately with the needed medication. All medication must be in original container with pharmacy label and brought in by parent or guardian.

___________________________________ ________________________
Signature of Parent/Guardian Date