LAKE ZURICH COMMUNITY UNIT
School District 95

NON-FOOD ALLERGY ASSESSMENT and CARE PLAN

For School Year: _____/_____ **School_____**

STUDENT:_____ Birthdate:_____Grade:_____

PARENT/GUARDIAN NAME:_____PHONE:_____

ADDRESS:_____

WORK PHONE:_____CELL PHONE:_____

PARENT/GUARDIAN NAME:_____PHONE:_____

ADDRESS:_____

WORK PHONE:_____CELL PHONE:_____

In the event we are unable to reach you:
EMERGENCY PHONE CONTACT _____
(other than parent) Name Relationship Phone

List your child's allergies:_____

When was your child's last significant allergic reaction:_____

Please check any symptoms that apply to you child's allergic reaction:

❑ Feeling of apprehension	❑ Sweating	❑ Weakness
❑ Feeling of fullness in throat	❑ Change in quality of voice	❑ Nasal Congestion
❑ Tingling sensation around mouth or face	❑ Respiratory difficulty	❑ Wheezing
❑ Itching	❑ Hives	❑ Rash
❑ Localized redness and swelling	❑ Low blood pressure	❑ Rapid pulse
❑ Other (be specific)		

Check medication your child requires in the event of an allergic reaction:

❑ Benadryl	❑ EPI-PEN	❑ Other (specify)

please complete both pages

If your child requires any medication in the event of an allergic reaction, the school must have a "Medication Authorization Form" on file, signed by both physician and parent.
A new medication form is due each school year. District policy requires medications to be brought to school by a parent or responsible adult. Students are permitted to carry EPI-PENs with the proper documentation in the health office.

Does your child carry an EPI-PEN at all times?_____Yes_____No

Where is (are) EPI-PEN (s) kept for student?_____

Has student been instructed in:_____Signs/symptoms of significant allergic reaction

_____Use of EPI-PEN

Does your child wear a "Medic Alert" bracelet?_____Yes_____No

EMERGENCY PLAN (Complete with input from your physician.)
List below a step by step plan for your child in the event he/she has an allergic reaction at school.

1._____

2._____

3._____

4._____

5._____

Additional comments
_____

_____

_____

Name of physician treating your child's allergy:_____

_____

Address Phone Fax

Physician's signature_____

May the school nurse contact the physician in case there are any questions or concerns in making an emergency plan for your child? Yes_____ No_____

_____ _____

Parent/Guardian Signature **Date**

3.2011