ALLERGY REACTION INFORMATION FORM

Student Name ____________________ DOB __________School ___________________ Teacher/grade ______________

Student's Physician ___________________________________ Phone/Fax __________________/___________________

Name	Title/Relationship	Home #	Cell#	Work#
	Mother/Guardian			
	Father/Guardian			
	Emergency Contact			

MEDICATIONS ____

What date did your 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 EPIPEN? ☐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,grass,pollen
☐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 Cons.
☐Other _________
☐Other _________
☐Other _________

Parent Signature: ____Date: ________________