Simi Valley Unified School District
Student Support Services 875 E. Cochran St. Simi Valley, CA 93065 805-306-4500

ALLERGY HEALTH RECORD UPDATE

Student _____ Date of Birth _____

School _____ Grade _____

Person completing this form: _____

Name of Physician: _____ Phone: _____

☐ **Allergies are no longer** an active problem for my child. Please update this information on my child's school record.

Current allergies include:

☐ Nuts (Please specify) _____

☐ Foods (Please specify) _____

☐ Bee Stings

☐ Other (Please specify) _____

Symptoms my child experiences (check all that apply):

☐ Apprehension/Anxiety or Sense of Doom ☐ Throat Tightness ☐ Hacking/Repetitive Coughing

☐ Difficulty Swallowing ☐ Wheezing ☐ Red, Watery Eyes ☐ Sneezing

☐ Short of Breath/Difficulty Breathing ☐ Swelling ☐ Change of Voice ☐ Itching

☐ Change of Skin Color (pale, blue) ☐ Diarrhea ☐ Rash ☐ Hives

☐ Fainting or Loss of Consciousness ☐ Nausea ☐ Vomiting ☐ Dizziness

☐ Other _____

History (allergy reactions):

☐ Has used Epi-pen ☐ Has called 911/Ambulance ☐ Has been hospitalized

Plan for care at school (check all that apply):

☐ **No** medication required – standard first aid only

☐ **Benadryl (Diphenhydramine)** - *Medication Authorization Form required*

☐ **Epi-pen** - *Medication Authorization Form required*

☐ Peanut-aware table required for snack/lunch

☐ Other _____

Parent/Guardian Signature _____ **Date** _____

Please return this update, along with any medications and authorization forms to the school office.