Watertown-Mayer Public Schools • ISD #111
Young Royals Preschool

Severe Allergy & Intolerance Information

_____ _____ _____ ____ / ____ / ____
Student's Name **Grade** **Age** **Date of Birth**

Allergy / Intolerance:	
Triggers	
Avoidance **Techniques**	
Symptoms:	❑ **Lung: Shortness of breath, wheezing, coughing Heart: Pale, blue, faint, weak pulse, dizzy, confused** ❑ **Throat: Tightness, hoarse voice, trouble breathing/swallowing Mouth: Significant swelling (tongue and/or lips)** ❑ **Skin: Redness/many hives over body** ❑ **Gut: Repetitive vomiting, severe diarrhea** ❑ **Other (describe)**
Procedures for Responding:	

Medications require a **parent/guardian signature AND physician's signature on Medication Authorization Form.**
Medication must always be documented on the *Authorization for Administration of Medication Tracking Log*

Medication	Dosage	Possible Side Effects

Other Considerations/Directions:

_____

_____

Emergency Contact:

Name/Relationship: _____ Phone#:_____

Physician Information:

Doctor:: _____ Clinic: _____

Phone#: _____ Fax#:_____

_____ _____
Parent/Guardian Signature Date