Other Allergies

Date:_____

*Please fill out this form and turn it in to your student's secretary. A new form must be completed every school year!
**A separate form must be filled out per allergy- only one allergen per form.

Student Name:_____ DOB:_____

School:_____ Teacher:_____

What is your student allergic to? _____
Does your student have an Epipen for this allergy? Yes: ☐ No: ☐
If yes, what kind/brand of Epipen does your student have? _____
Where is the Epipen located? (Please check all that apply.) Office: ☐ Student Backpack: ☐ Student Locker: ☐
Does your student take Benadryl for an allergic reaction? Yes: ☐ No: ☐
(Please explain/provide specific instructions.)
Does your student take any other medications when having a reaction? Yes: ☐ No: ☐
(Please explain/provide specific instructions)
What are your student's allergic reaction symptoms? (Please check all that apply.)
LUNGS: (Breathing Problems) Wheezing: ☐ Shortness of Breath: ☐ Coughing: ☐ Difficulty Speaking: ☐
THROAT: (Upper Airway Problems) Hoarseness: ☐ Swallowing Difficulty: ☐ Breathing Difficulty: ☐
HEART: (Circulation Problems) Blue lips: ☐ Faint: ☐ Dizziness: ☐
GUT: (Intestinal Reactions) Vomiting: ☐ Cramping: ☐ Diarrhea: ☐
SKIN: Hives: ☐ Redness: ☐ Swollen Face: ☐
MOUTH: Swelling of lips: ☐ Swelling of tongue: ☐ Metal Taste: ☐
BRAIN: (Mental Changes) Feeling of Impending Doom: ☐ Anxiety: ☐ Confusion: ☐
Other Symptoms: _____ ☐
Have you filled out the form: _____ for your student for this school year and given a copy to the office? Yes: ☐ No: ☐ (*If you have not, please obtain the form, fill it out, and turn it in!)
Do you have a Care Plan or Action Plan from your student's Doctor? (Please attach a copy if so!) Yes: ☐ No: ☐

Additional Comments: _____
_____
_____
_____
_____

Parent/Guardian Name (printed): _____

Other Allergies

Date:_____

*Please fill out this form and turn it in to your student's secretary. A new form must be completed every school year!

**A separate form must be filled out per allergy- only one allergen per form.

Signature:_____