

Allergy Action Plan & Emergency Health Information Sheet Form B

Student's Name: _____ D.O.B _____ Grade: _____

ALLERGY TO (list all): _____

Asthma: Yes* ☐ No ☐ *Higher risk for severe reaction
Epipen Prescribed by MD: Yes ☐ No ☐ Inhaler Prescribed by MD: Yes ☐ No ☐
If your child suffers an allergic reaction, do we have your permission to administer Benadryl? Yes ☐ No ☐

ALLERGY ACTION PLAN

Symptoms:

- For Severe Allergy and Anaphylaxis:
 - For Mild Allergic Reaction:
 - For Exposure to allergen, but no symptoms:
 - Other: _____
- The severity of symptoms can change quickly.

Give Checked Medication:

- | | |
|---------------------------------|--|
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr.

Antihistamine: _____
medication/dose/route

Other: _____
medication/dose/route

EMERGENCY CONTACTS

Emergency contacts: Please list parent(s) and at least two additional contacts in the event parent(s) cannot be reached.

Name:	Relationship to child	Phone #1	Phone #2
1.			
2.			
3.			
4.			

IF PARENT/GUARDIAN CANNOT BE REACHED, STAFF WILL NOT HESITATE TO MEDICATE OR TAKE CHILD TO A MEDICAL FACILITY!

OTHER HEALTH INFORMATION

Do any of the following conditions apply (please circle)?

1. ADD /ADHD	4. Anxiety	7. Arthritis	10. Asthma	13. Bladder Control	16. Constipation
2. Developmental Delay	5. Diabetic	8. Gastric reflux	11. Hearing Loss	14. Heart Issues	17. Kidney
3. Migraines	6. Nosebleeds	9. Panic/Anxiety	12. Seizures	15. Glasses/Contact Lenses	18. Other (explain)

Does the student have any physical limitations? _____

Please list all medications your child takes at school or home (for monitoring side effects). Include Medication, Time of Day, and Dose: _____

Primary Care Provider:	PCP Phone #:	Desired Hospital:	
Insurance Company:	Insurance Policy #:	Dentist:	Phone #

**Medications necessary to be given during the school day, either daily or as needed, must have a written physician's order, written parental permission, and be supplied and delivered by parent in the original container. This applies to prescription and non-prescription medications.

This information is accurate. I understand that in case of injury, the school is responsible for First-Aid treatment only. I also understand that the school will share, confidentially with appropriate personnel, medical information deemed necessary in order to provide optimum safety for my child.

Parent's signature _____ Date _____

MEDICAL RELEASE

I authorize Congregation Shalom to take measures deemed necessary to seek or administer medical treatment for my child in the event of any emergency. This authorization applies to incidents at the school and/or on field trips. I understand that I will be contacted immediately.

Parent's signature _____ Date _____