Universal School

Student Allergy or Chronic Illness Information

Student Name_____ **Grade** _____ **Contact** _____

Home Number _____ **Cell Number**_____

ALLERGY:

Asthmatic/Respiratory Allergies	Yes	No	*Higher risk for severe reaction
Food Allergies		Yes	No *Higher risk for severe reaction

Detailed Description of allergies:

_____

_____

TREATMENT:

For medications administered during school sanctioned activities, complete required Epipen/Twinject/Medication Authorization forms.

SYMPTOMS:	**ADMINISTER MEDICATION:**	
• If a food allergen has been ingested *but no symptoms*	Epinephrine	Antihistamine
• Mouth itching, tingling or swelling of lips, tongue or mouth	Epinephrine	Antihistamine
• Skin hives, itchy rash, swelling of the face or extremities	Epinephrine	Antihistamine
• Throat* Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
• Lung* Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
• Heart* Pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
• Other*_____	_____	

DOSAGE:

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

Antihistamine:_____

medication/dose/route

PLACE EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.

2. Dr's Name: _____ Phone Number: _____

EMERGENCY CONTACTS:

	Name	**Relationship**	**Phone Number**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I give permission for school personnel to perform and carry out the task as outlined. I consent to the release of the information contained in this document to all staff members and others who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____ _____

Parent's Signature **Date**