Dear Parent/Guardian: Thank you for providing this information to us to help keep your child safe and healthy at school. Your school nurse will be in contact with you if follow up information is needed. Please return all forms to your child’s school office or email them to hservices@mesd.k12.or.us

Child’s Name:       Date of Birth       Today’s Date

School:

Parent/Guardian(s):

Health Care Provider:       Phone       Fax

**History:**

When was your child diagnosed with a severe allergy?

What is your child severely allergic to?

Describe the reaction:

How quickly do symptoms appear?

Do the reactions seem to get worse with each exposure?  Yes  No

Has your child required treatment in the emergency room for SAR?  Yes  No

If yes, when:

**Treatment:** For students in grades K-5, or student’s requiring extra help, medications/equipment should be kept in the health room or other agreed upon, secure location. **All medications at school must be kept in their original containers. Prescription medications must have pharmacy labels attached.**

How is your child’s severe allergic reaction treated?  Epinephrine  Antihistamine  Other

Will your child have the above medication(s) at school?  Yes  No

If yes, which ones?

Will your child need help administering the medications if experiencing an allergic reaction?

Yes  No If yes, which ones?

Will your child be carrying their own medication(s) on them during the school day?  Yes  No

If yes, which ones?

Have you provided a current set of health care provider orders to the school?  Yes  No