Richmond School www.richmond.k12.wi.us
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Phone 262-538-1360 Fax 262-538-1572

School Year_____

FORM C: ALLERGY INFORMATION SHEET
FOR STUDENTS REQUIRING ALLERGY MEDICATION AT SCHOOL

Student's Name _____Home phone number _____

Date of Birth_____ Grade & Teacher _____Weight_____/_____date of form completion)

Parent/Guardian's Name _____ Work phone number _____Cell Phone _____

Parent/Guardian's Name _____Work phone number _____ Cell Phone _____

Other Emergency Contact_____ __ Ride the bus? Yes____ No_____ Route #_____

Doctor's Name _____ __ Doctor's phone number _____

ALLERGIC TO: (please include medications, foods, insects, latex, etc)

_____

Asthmatic Yes* _____ NO _____ *High Risk for severe reaction

Health History
Do you believe your child would recognize if she/he were having an allergic reaction? Yes ____ No ____ Unsure ____
Has your child ever received epinephrine for a past allergic reaction? Yes ____ No ____ If so, please provide date:_____
*If so, were they transported to the hospital? Yes ____ No ____
Has your child ever used an antihistamine for relief of a past allergic reaction? Yes ____ No ____
Has your child ever needed to use an inhaler (bronchodilator) while experiencing an allergic reaction? Yes ____ No ____

Please list any other medications that have been used for past reaction(s) _____

Please circle all symptoms that your child has experienced in past reactions.

Skin: Itching, Rash, Hives, Swelling of the Face, Swelling of the Extremities

Eyes: Watery eyes, Red eyes, Itchy Eyes,

GI: Nausea, Abdominal Cramps/Pain, Vomiting, Diarrhea

Mouth: Itchy /Scratchy Lips/ Mouth /Tongue , Swelling of Lips/Mouth /Tongue

Throat: Itching, Hoarseness, Cough, Sense of Tightness in Throat, Swelling/Closing of Throat, Difficulty Swallowing

Lungs: Shortness of Breath, Wheezing, Repetitive Coughing

Heart: Low Blood Pressure, Dizziness, Irregular heartbeat, Faintness /Loss of Consciousness, Flushed or Pale skin, Shock

Miscellaneous: Change in Voice, Mental Status Change

Please describe any past reactions and note any words or phrases your child may use to describe the allergic reaction.
List approximate age when reaction occurred.

_____

_____

TREATMENT PLAN

Richmond's trained staff will be following the **FORM A: ALLERGY ACTION PLAN –EMERGENCY CARE PLAN.** This form needs to be completed by your child's health care provider. Please contact the Health room when any medical changes occur for your child.

Has your physician recommended classroom modifications to ensure your child's safety? Yes____ No____

If yes, please specify:_____

_____

Richmond's Allergic Action Protocol:

1. Faculty will call the health room personnel to report reaction.
2. Follow procedures from **FORM A: Allergy Action Plan - Emergency Care Plan Sheet** (all students with epinephrine at school need this form on file in the health room).*This form is a comprehensive guide on when to use epinephrine, antihistamine, additional medication and when to call 911.
3. Administer any additional medications physician ordered-this should be included on the **FORM A: Allergy Action Plan - Emergency Care Plan** under the heading of medication/other.
4. Administer **CPR** if necessary.

Parental Consent:

- I hereby give my permission for the health room personnel, office staff or authorized school personnel to give the medications to my child according to the directions stated above.
- I give permission to the school to contact the student's physician if needed.
- I further agree to hold the Richmond School District harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.
- I agree to notify the health room at the termination of this request or when changes in the below order is necessary.
- If my child requires the use of Epinephrine for an allergic reaction, 911 will be called immediately. My child will be transported to the nearest hospital, unless hospital preference is listed.

_____.
Preferred Hospital name

_____ _____
Date Signature of Parent/Legal Guardian