TV 204 (6/15)

MEDICAL DOCUMENTATION OF AN ALLERGY

Student: ________________________ Date of Birth: _________ Grade/Teacher: ___/________

Parent: _____________________________ Phone Nos. ________________/________________

Parent: _____________________________ Phone Nos. ________________/________________

Emergency Contact: __________________ Phone Nos. ________________/________________

The following is to be completed by your child's health care provider. A separate form must be completed for each allergy.

Allergy to: _______________________________________ Asthma: [] YES [] NO

High Risk of Anaphylaxis: [] YES [] NO

ANAPHYLAXIS-CAUSING ROUTES OF EXPOSURE (CHECK ALL THAT APPLY):

[] Ingestion [] Touch [] Inhalation [] Other: ________________________

Signs of an allergic reaction for this child include (Indicate all that apply):

MOUTH	Itching and/or swelling of the lips, tongue, or mouth
THROAT	Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
SKIN	Hives, itchy rash, and/or swelling about the face and extremities
GUT	Nausea, abdominal cramps, vomiting and/or diarrhea
LUNG	Shortness of breath, repetitive coughing, and/or wheezing
HEART	"Thready" pulse, loss of consciousness

Describe past allergic reactions including triggers, warning signs, and dates:

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Describe the student's emotional response to the reaction and need for support:

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* "Medication Permission" forms, additional medical orders, and/or pertinent medical information must be attached.

Physician's Name (Print or Stamp): ______________________Date:________ Phone No.: ___________________________

Physician's Signature: ____ Parent's Signature: ___________Date:__________