NON-FOOD ALLERGY ASSESSMENT and CARE PLAN

Date:_____

Child's Name: _____ **Birthdate:**_____ **Age:**_____

List your child's allergies:_____

When was your child's last significant allergic reaction:_____

Please check any symptoms that apply to you child's allergic reaction:

❑ Feeling of apprehension	❑ Sweating	❑ Weakness
❑ Feeling of fullness in throat	❑ Change in quality of voice	❑ Nasal Congestion
❑ Tingling sensation around mouth or face	❑ Respiratory difficulty	❑ Wheezing
❑ Itching	❑ Hives	❑ Rash
❑ Localized redness and swelling	❑ Low blood pressure	❑ Rapid pulse
❑ Other (be specific)		

Check medication your child requires in the event of an allergic reaction:

Name:	Dosage:	Exp. Date:
Name:	Dosage:	Exp. Date:
Name:	Dosage:	Exp. Date:

please complete both pages

If your child requires any medication in the event of an allergic reaction, the school must have a "Medication Authorization Form" on file, signed by both physician and parent.
A new medication form is due each school year. All medication should be dropped off at the school office.

Does your child wear a "Medic Alert" bracelet?_____Yes_____No

<u>EMERGENCY PLAN</u> (Complete with input from your physician.)
List below a step by step plan for your child in the event he/she has an allergic reaction at school.

1._____

2._____

3._____

4._____

5._____

<u>Additional comments</u>

_____

_____

_____

Dr. Name:	Dr. Phone #:
Dr. Signature:	Date:

_____ _____
Parent/Guardian Signature **Date**