Lehman Catholic High School

ALLERGY/ANAPHYLACTIC REACTION HISTORY

Student Name ..... Date of Birth .....

Street ..... City ..... State ..... Zip .....

Parent / Guardian Name ..... Phone .....

Physician Name ..... Phone .....

According to our records, you have informed the school that your child has a history of allergic/anaphylactic reactions. Please complete the information below. This will help the school staff know more about your child and his/her medical condition and the best way to protect the health and safety of your child while at school.

Check any life-threatening allergy this student has.

- ☐ Insect Stings List Type .....
- ☐ Food List Type .....
- ☐ Animals List Type .....
- ☐ Other List Type .....

Indicate the signs that are usually present during an allergic reaction.

- ☐ Difficulty breathing
- ☐ Very pale skin
- ☐ Swelling | where? ..... how much? .....
- ☐ Rash
- ☐ Loss of consciousness
- ☐ Nausea
- ☐ Difficulty swallowing
- ☐ Flushed skin
- ☐ Other .....

Has emergency medical treatment been needed in the past for allergies/allergic reactions?

- ☐ YES, When? .....
- ☐ NO

Does your student have an EPI pen?

- ☐ YES
- ☐ NO

If you plan to have medication available at school, medication forms must be completed and signed by you and your doctor (your physician MUST complete the request for medication administration). This form is required before any medication can be given at school.

If a bee or wasp sting occurs at school, your child will be given basic first aid. You will be notified. If necessary, your child will be transported by rescue squad to the nearest hospital as designated on the student's emergency medical form.

Please contact the public health/school nurse if you have any questions or if your child's medical condition changes during the school year. Thank you for your cooperation and help in providing the best care for your child.

Parent/Guardian Signature ..... Date .....