NAME: ______________________________ ______________________________
FIRST NAME **LAST NAME**

ADDRESS: ____
____

HOME PHONE: ____

EMERGENCY PHONE: ____

PARENT/GUARDIAN WORK PHONE: ______________________________

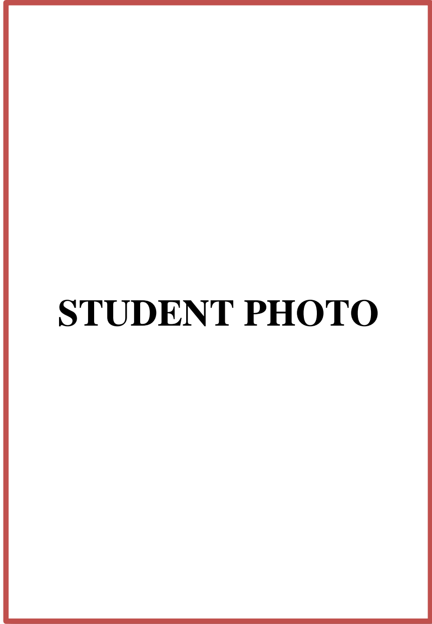
PARENT/GUARDIAN WORK PHONE: ______________________________

TEACHER: ____

CLASS: __________________ **ROOM #:** ____________________________

PHYSICIAN ____

PHYSICIAN'S TELEPHONE ______________________________________



______________________________ ______________________________
HEALTH CARE CARD # **HEALTH CARE CARD PROVIDER'S SIGNATURE**

______________________________ ______________________________
PHYSICIAN NAME **PHYSICIAN'S TELEPHONE**

ALLERGY-DESCRIPTION:

This child has a **DANGEROUS**, life-threatening allergy to the following items and to all foods containing them in any form in any amount:

____

____

AVOIDANCE: The key to preventing an emergency is **ABSOLUTE AVOIDANCE** of these foods **at all times**.

WITHOUT AN EPI-PEN® THIS CHILD MUST NOT BE ALLOWED TO EAT ANYTHING containing these allergens.

EATING RULES: (If any, list eating rules for child)

____

____

POSSIBLE SYMPTOMS:

- ☐ Flushed face, hives, swelling or itchy lips, tongue, eyes
- ☐ Tightness in throat, mouth, chest
- ☐ Difficulty breathing or swallowing, wheezing, coughing, choking
- ☐ Other ________________________________
- ☐ Vomiting, nausea, diarrhea, stomach pains
- ☐ Dizziness, unsteadiness, sudden fatigue, rapid heartbeat
- ☐ Loss of consciousness

ACTION – EMERGENCY PLAN:

At any sign of difficulty (e.g. hives, swelling, difficulty breathing):

- ☐ Use EPI-PEN® immediately
- ☐ Even if symptoms subside entirely, this child must be taken to a hospital immediately.

EPI-PEN(S)® are kept:

- ☐ with student
- ☐ in the student's classroom
- ☐ School Office
- ☐ Staffroom

______________________________ ______________________________

PARENT NAME (PLEASE PRINT) **PARENT SIGNATURE**