Allergy and Asthma Alert Form

Student's Name:_______________________________________D.O.B: ___________________________

Does your child have an Allergy? …………………………………………………………. YES NO

Is your child at high risk for a severe reaction? ………………………………………….... YES NO

Allergy to: ____

Signs your child is having an allergic reaction please check symptoms below

Systems	Symptoms	X
Mouth	Itching, 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 or extremities	
Gut	Nausea, abdominal cramps, vomiting, and/or diarrhea	
Lung	Shortness of breath, repetitive coughing, and/or wheezing	
Heart	Rapid pulse, passing out	

Does your child have Asthma? ……………………………………………………….. YES NO

Is your child at high risk for a severe reaction?... YES NO

Signs your child is having an asthma attack please check symptom below

Symptoms	X
Coughing	
Shortness of breath	
Tightness of the chest	
Wheezing	

Does your child require medication to be kept at school………………………………… YES NO

Does your child have a Medication Authorization form on file in the school office…….. YES NO

Please list any medications that are on file in the school office for your child: ______________________________

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1-EMERGENCY CONTACT NAME_________________________**PHONE #**__________________________

2-EMERGENCY CONTACT NAME_________________________**PHONE#**___________________________

Parent/guardian signature:_______________________________________ Date: ____________________