Allergy Notification Form

Child's Name: ____________________________________ DOB __________________
Allergist: ____ Phone: _________________

1. Does your child have a diagnosis of an allergy from a healthcare provider? [ ] No [ ] Yes

2. History and Current Status

a. What is your child allergic to? [ ] Peanuts [ ] Insect Stings [ ] Eggs [ ] Fish/Shellfish [ ] Milk [ ] Latex [ ] Tree Nuts (walnuts, pecans, etc.) [ ] Other: _______________________________ _______________________________ _______________________________ _______________________________	b. Age of student when allergy first discovered: ____________________ c. How many times has student had a reaction? [ ] Never (Diagnosed by a test) [ ] Once [ ] More than once, explain: ____ d. Symptoms: [ ] Severe: trouble breathing, swelling of tongue/lips, vomiting, severe diarrhea, hive all over body, etc [ ] Mild: Itchy/runny nose, itchy mouth, few hives, mild itching of skin, etc

3. Trigger and Symptoms

   a. What are the early signs and symptoms of your child's allergic reaction?
   ____

   b. How quickly do symptoms appear after exposure to food(s)? _____________________________

4. Treatment

   a. What treatment or medication has your healthcare provider recommend for use in an allergic reaction? *(please ask your physician to fill up the authorization to administer medication form if any)*
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____ ______________________
Parent/Guardian Signature Date