BARRINGTON 220
COMMUNITY UNIT SCHOOL DISTRICT

ANNUAL ALLERGY UPDATE

Student Name: _____ Date of Birth:_____ Date: _____

Parent / Guardian:_____ Phone:_____

We are aware of your child's allergy to_____

During the previous school year, your child had the following medication(s) at school:
☐ EpiPen ☐ Antihistamine ☐ Inhaler

These medications were ordered for self-administration: ☐ YES ☐ NO

Will child self-carry their emergency medication this year? ☐ YES ☐ NO

Is your child wearing a ***Medic Alert*** bracelet? ☐ YES ☐ NO

Does your child need training on how to administer an EpiPen? ☐ YES ☐ NO

If applicable, a copy of the previous emergency health care plan is attached. Please review and contact school nurse regarding suggested revisions.

If your child does not have medication at school to treat a possible allergic reaction, do you feel that this may be necessary? ☐ YES ☐ NO

What signs are usually present during an allergic reaction? (Check all that apply)

_____ difficulty breathing
_____ difficulty swallowing
_____ loss of consciousness
_____ swelling
____ rash/hives nausea/vomiting
____ flushed/unusually pale color
____ ____ other _____

Health Care Provider (name) treating allergy:_____
Phone:_____

I have had my child tested for allergies: ☐ YES ☐ NO
If yes, please list pertinent results:_____
_____

When was your child's last allergic reaction?_____

Please describe the signs and symptoms of the reaction._____
_____

What medical treatment was provided and by whom?_____
_____

If medication is to be available at school, the medication form and/or anaphylaxis action plan must be completed by both the licensed medical provider and the parent/guardian. Parent/guardian is responsible for bringing the medication/treatment supplies to school.
Reviewed by RN:_____ Date:_____