CACHE PUBLIC SCHOOLS – SEVERE ALLERGY HEALTH FORM

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

Parent/Guardian #1: _____ Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Parent/Guardian #2: _____ Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Emergency Contact: _____ Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Doctor/Health Care Provider: _____ Telephone: _____

Hospital of Choice: □ Comanche County Memorial □ Southwestern □ Reynolds □ Lawton Indian

NATURE OF ALLERGY/ALLERGENS

Check all that apply:

□ Peanuts □ Tree Nuts □ Milk/Dairy □ Eggs □ Wheat □ Seafood/Fish □ Soy □ Latex

□ Scented Products □ Insects _____ □ Animals _____

Other: _____

Student reacts to allergen by: □ Ingestion □ Contact □ Inhalation

SYMPTOMS OF REACTION

Check all that apply:

□ Itching □ Hives/Rash □ Facial swelling □ Difficulty breathing □ Swelling of throat/tongue

□ Swelling of lips/eyes □ Difficulty swallowing □ Difficulty talking □ Coughing

□ Abdominal pain/cramps □ Nausea/vomiting □ Tingling of the throat □ Redness in the face

□ Other _____

* How many times has the student had an anaphylactic reaction? _____

* How many times has the student had a mild or moderate reaction? Mild _____ Moderate _____

* Does the student's allergies require him/her to carry an Epinephrine pen/device at school? □ Yes □ No

If yes, see below:

- According to State Law 70 O.S. 1-116.3, students may carry their Epinephrine pen/device on their person with the following conditions:
  - A Self Administered Anaphylaxis Medication Authorization Form (form #5) must be completed by the physician and parent.
  - An emergency backup Epinephrine pen/device must be supplied and kept in the office.

If no, see below:

- A Prescription Medication Authorization Form (form #1) must be completed by the physician and parent.
- The Epinephrine pen/device will be kept in the office.

* Please list all medications the student takes related to his/her severe allergies:

Medication Name	Dosage	Time/How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Instructions or Information: _____

_____

_____

This Severe Allergy Health form is approved by:
*** Required ***

Physician Name/Title: _____ (Please print or type)

Physician Signature: _____ Date: _____

Telephone: _____ Fax: _____ Address: _____

Parent/Guardian Signature _____ Date: _____