Benton Elementary
Phone: 574-831-2192
Fax: 574-831-2200

Fairfield Jr-Sr High
Phone: 574-831-2184
Fax: 574-831-2187

Fairfield Community Schools
Health Services
2020 - 2021

Millersburg Elem. & Middle
Phone: 574-642-3074
Fax: 574-642-3918

New Paris Elementary
Phone: 574-831-2196
Fax: 574-831-3160

ALLERGIC REACTION PARENT INFORMATION FORM

You indicated on school records that your child, _____ Grade _____ has a history of an Allergic Reaction. It is important to have a health information update annually should your child need help at school. **Please answer in detail the following questions and return these forms to Health Services by the next school day. Please attach additional information or special instructions. If you have questions or concerns, please contact the school nurse.**

HISTORY

1. Has your child been diagnosed with an allergy by a Health Care Provider ☐Yes ☐No If Yes, when?_____

2. Is this allergy life threatening? ☐Yes ☐No

3. Please identify the things that cause an allergic reaction. (Check all that apply, and explain in space given below)

- ☐ **Foods:** ☐Peanut ☐Treenuts ☐Fish ☐Shellfish ☐Eggs ☐Milk ☐Soy
- ☐ **Other Foods:** (Please list)_____
- ☐ **Insect Stings:** (Please list the type of insect causing the reaction) _____
- ☐ **Latex**
- ☐ **Chemicals**
- ☐ **Vapors**
- ☐ **Other:**_____

Please explain all checked boxes: _____

_____

4. How many times has your child had a reaction ☐ Never ☐Once ☐More than once
5. Date of your child's last reaction?_____
6. Does your child have asthma? ☐Yes ☐No

SYMPTOMS:

1. Please describe what happens at the onset and during a reaction, how quickly symptoms appear, etc. (Be as specific as possible)

2. Are the symptoms of the reaction changing with each exposure? ☐Same ☐Better ☐Worse
3. How quickly after exposure do symptoms appear?

TREATMENT:

1. How have past reactions been treated? ☐No treatment required ☐Antihistamine (Benadryl) ☐Nebulizer (breathing) treatment ☐Inhaler ☐Epipen (Epinephrine) ☐Other
2. How did your child response to treatment?
3. Have you had to seek emergency room treatment for a reaction? ☐Yes ☐No If yes, please explain

4. Date of your child's last appointment with their Health Care Provider?
5. List treatments or medications the Health Care Provider recommended for treating or controlling an allergic reaction:

FORM CONTINUES ON REVERSE SIDE ⇨

Student's Name_____ **Grade**_____

TREATMENT: (Continued)

6. Is your child prescribed any of the following medications? ___EpiPen/Epinepherine ___Benadryl ___Other:_____

7. If your child is exposed to an allergen or experiences an allergic reaction during the school day, they will come to the office and be closely monitored and treated. If your child is not better after using *their* emergency allergy treatment medications, you will be contacted, and 911 may be called. **NOTE: If an EpiPen is used, 911 will be called, and the parent/guardian will be contacted.**

Please list daytime phone numbers where you can be reached:

Parent/Guardian Name:_____ Parent Phone Number: _____

Parent/Guardian Name:_____ Parent Phone Number: _____

Other Emergency Contact/Relationship_____ Phone Number: _____

STUDENT ABILITY FOR SELF CARE:

1. How does your child avoid exposure to the allergen?

2. Does your child recognize symptoms of an allergic reaction?

3. Will your child communicate these symptoms to an adult and what would they say?

4. Does your child wear a Medical Alert bracelet/necklace?

5. Will your child **carry** (See ***NOTE*** below) emergency treatment medication during the school day and/or to school-related activities? ☐Yes ☐No

******NOTE***If your child will carry emergency allergy treatment medication, the state law requires that a form signed by a Health Care Provider must be on file in the school.*** This form is enclosed and needs to be completed, signed and returned to the office by the 1st day of school; or if school is in session, please return it the next school day if possible. Parents and Students must also sign an authorization form (provided after the Health Care Provider Authorization is returned.) As with all prescription medications, your child must supply their own medications. It is recommended additional medication be kept in the clinic in the event your child fails to self-carry the medication.

Please include additional comments here, or attach additional forms:_____

_____

_____

_____

I certify that the above information is complete and accurate. I give permission for this information to be released to necessary staff at my child's school. This information will be kept confidential, but may be used to assess the need for treatment in the event of a medical problem. I agree to notify the nurse immediately of any changes in my child's condition or medications or in changes of emergency phone numbers. If the Allergic Reaction Parent Information Form for the current year is not signed by the parent and/or provided to the school, the most recent signed Allergic Reaction Parent Information Form available will be followed until the school receives an updated form.

_____ _____

Parent/Guardian Signature Date Signed