



Medically Documented Life Threatening Allergy

(See Guidelines on Reverse Side)

Part I- To be completed by parent/legal guardian:

Student _____ Birth Date _____ School _____ Grade _____ School Year _____

Parent/ _____ Home Phone _____ Work _____ Cell _____
Legal Guardian

Parent/Legal Guardian Signature _____ Date _____

Part II- To be completed by child's health care provider:

This child has a documented life threatening allergy(s) to: _____

This child may experience the following symptoms when exposed to the allergen(s): _____

The time from exposure to onset of symptoms is: _____

Actions to take if **exposure is suspected** (include time factors): _____

Actions to take if **exposure is known** (include time factors): _____

Is this child Asthmatic? Yes* _____ No _____ (* Higher risk for severe reaction)

- Student and parent/legal guardian have been instructed by me on the above allergy(s) and actions to take if exposed or exposure suspected.
- I recommend that this student wear medical identification for this medically documented life-threatening allergy.

Health Care Provider's Name _____ Phone _____ FAX _____

Health Care Provider's Signature _____ Date _____

Part III- To be completed by school office:

Original form to be filed in Medication Administration Binder with completed *Medication Request and Authorization* form.

- A copy of this form is:
- to be given to school's head cook and District Food Services Manager (food allergies only)
 - to be given to District school nurse
 - to be filed in student's health file in cumulative folder