



ALLERGY FORM
TBJ ECC 2019-20 ALLERGY FORM

FIRST NAME _____ LAST NAME _____ AGE _____

Many children are allergic or sensitive to certain food groups. Unfortunately, this information is not always completed on medical forms. To insure that we do not provide anything incompatible to your child, please complete this form.

Cell Phone Number: _____ Home Phone: _____

ALLERGIES:

Known Allergies:

Food(s): _____ Reaction: _____

Medicine(s): _____ Reaction: _____

Insect Bite(s): _____ Reaction: _____

Other: _____ Reaction: _____

NOTE: Allergy Action Plan Form MUST be submitted with instructions for the treatment of an allergic reaction.

<input type="checkbox"/> My child has a history of asthma	Explain if box is checked
<input type="checkbox"/> Or is currently being treated for asthma	Explain if box is checked
<input type="checkbox"/> My child has a history of eczema	Explain if box is checked

AUTHORIZATION FOR NON-PRESCRIPTION MEDICATIONS:

In the event of a minor medical emergency or illness, the School Nurse has my permission to administer the following over-the-counter medications according to the label instructions.

Acetaminophen (Tylenol) for discomfort, pain, fever	Yes	No
Ibuprofen (Advil/Motrin) for discomfort, pain, fever	Yes	No
Diphenhydramine Liquid or Cream (Benadryl) for allergic reactions, hives, severe itching	Yes	No
Antibiotic Ointment (Neosporin) for minor wounds	Yes	No

If your child should have an allergic reaction OR an asthma flare, we will call you immediately. Please give us any comments or instructions that will make your child more comfortable in this situation.

My child has NO allergies. I have read the above information.

Parent Signature _____ Date _____