



**Allergy Management Plan and Parent Authorization for Antihistamine
 (For non-anaphylactic allergies)**

Student name	DOB	Grade
Parent(s)/Guardian(s)	School/teacher	
Parent/Guardian Phone Numbers Home: _____ Work: _____	Cell: _____	
Emergency Contact (other than Parent/Guardian)	Emergency contact phone: _____	
Physician/Phone	Hospital/Phone	

ALLERGIES (Check all that apply): _____ Animals _____ Bee/insect stings _____ Dust/dust mites _____
 Latex _____ Molds _____ Pollen _____ Strong odors/fumes _____
 Foods: _____
 Medications: _____
 Other: _____

HISTORY

1. Does your child know what allergies he/she has? Yes No
2. Does your child know when to contact an adult for help? Yes No
3. Has your child gone to the emergency room for allergy symptoms? Yes No
4. Has your child had a life threatening anaphylactic allergic reaction? Yes No
5. Is your child treated with an antihistamine? Yes No

SIGNS OF AN ALLERGIC REACTION -- Circle allergy symptoms your child has had:

- **Eyes:** red, watery, itchy
- **Nose:** runny, stuff, sneezing
- **Mouth:** itching, swelling of lips, tongue, or mouth
- **Heart:** weak pulse, passing out, increased heart rate
- **Throat:** itching, tightness, hoarseness, hacking cough, difficulty swallowing
- **Skin:** hives, itchy rash, swelling of the face or extremities, or other areas
- **Stomach:** nausea, stomach cramps, vomiting, diarrhea
- **Lungs:** shortness of breath, coughing, wheezing, difficulty breathing

(Continued on Back Side)

WHAT SHOULD SCHOOL STAFF DO TO CARE FOR YOUR CHILD IF HE/SHE SHOWS SIGNS OF AN ALLERGIC REACTION

1. _____
2. _____
3. _____
4. _____

PARENT CARE AUTHORIZATION:

- I understand that school personnel will make good faith efforts to provide medical care to my child and acknowledge school personnel will not be held legally or financially responsible for this care.
- I will notify the school immediately of any changes in my child's health status or medication.
- I give permission to School personnel to contact my child's physician as needed; and that education/health information may be shared with staff who need to know.

Parent/Guardian Signature of Approval (Required): _____ **Date:** _____

If your child requires medication for his/her allergy, please fill out the following authorization and bring medication to school. Medication must be in its original container with label attached – small containers preferred.

MEDICATION AUTHORIZATION:

Medication name: _____ **Strength:** _____ **How many:** _____

Instruction for use: _____

Medication side effects: _____

Other information staff should know about student and this medication: _____

As parent/guardian of the above-named child, I give permission to Dickinson Public School personnel to administer the above-named medication to my child; I also acknowledge school personnel will not be responsible, legally, or financially, for the administration of this medication.

Parent/Guardian Signature of Approval (Required): _____ **Date:** _____

**Form valid for one year from date of signature unless changes in medical status.*