FWCS
WE ARE YOUR SCHOOLS

Health Services
1200 South Barr Street • Fort Wayne, IN 46802 • Phone: 260.467.1080 • Fax: 260.467.2862

Allergic Reaction Parent-Physician Information 2019-20

PARENT INFORMATION

Student: _____ Grade: _____ DOB: _____ Room: _____

Parent/Legal Guardian Name: _____ Daytime Phone: _____ Cell: _____

Emergency Phone Contact #1: _____ Relationship: _____ Daytime Phone: _____ Cell: _____

Emergency Phone Contact #2 _____ Relationship: _____ Daytime Phone: _____ Cell: _____

Family Doctor: _____ Telephone: _____ Allergy Doctor: _____ Telephone: _____

Hospital Preference ☐ Lutheran (W. Jefferson) ☐ Lutheran (Dupont) ☐ Parkview (North) ☐ Parkview (Randallia) ☐ Saint Joseph

Identify the things that may trigger allergic symptoms in your child - Check all that apply

☐ Animals ☐ Bee/Insect ☐ Latex ☐ Medication ☐ Food allergy (list foods) _____
☐ Seasonal ☐ Pollens ☐ Other: _____

Symptoms -Check all that apply

☐ Hives, itchy rash ☐ Localized swelling ☐ Swelling of face ☐ Itching & swelling of the lips, tongue, or mouth ☐ Tightness in the throat, hoarseness

☐ Nausea, abdominal cramps, vomiting, diarrhea ☐ Shortness of breath, repetitive coughing, wheezing ☐ Rapid heart rate ☐ Passing out ☐ Other _____

Other Information –Check all that apply

☐ My child has an EpiPen prescribed ☐ My child knows how to properly use an EpiPen ☐ My child has an inhaler prescribed ☐ My child eats school lunch

Note: 911 will be called immediately when an EpiPen is administered at school. If school nurse is not available EpiPen may be administered by trained unlicensed staff in the school setting.

Emergency Medications – ***What medication/s does your child take for emergency allergic symptoms?***

Medication Name	Amount	Given for what symptoms
1		
2.		
3.		

Outside Activity and Field Trips. ***The following medications should accompany my child when participating in outside activity and field trips*****. Include DIRECTIONS**

1.	2.

I agree that this information (plan) may be shared with the appropriate staff members, who work with the student, on a need to know basis. I hereby release Fort Wayne Community School District and any of its agents, employees, administrators, from any liability for any injury or harm which is suffered by my child as a result of our District's agreement to honor the above request. I agree to allow the school nurse to contact my physician about my child's allergy treatment plan for school. I agree to keep the school nurse updated in writing about my child's health, and contact the school nurse in writing if any changes are made in the plan.

Parent Signature:	**Date:**

FWCS
WE ARE YOUR SCHOOLS

Health Services
1200 South Barr Street • Fort Wayne, IN 46802 • Phone: 260.467.1080 • Fax: 260.467.2862

Allergic Reaction Parent and Physician Information 2018-19

PHYSICIAN INFORMATION *This section is only to be filled out by the health care provider and is only necessary for the special circumstances listed below.*

Student Name_____ D.O.B. _____

This student has an allergy to _____and will require the following modifications to the school day to ensure his/her safety and wellbeing.

Student will need emergency medications for the following symptoms:

If student is stung or a food allergen has been ingested, but NO SYMPTOMS	☐ Epinephrine	☐ Diphenhydramine	☐ Rescue Inhaler
Mouth: itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Diphenhydramine	☐ Rescue Inhaler
Skin: hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Diphenhydramine	☐ Rescue Inhaler
Gut: nausea, abdominal cramps vomiting, diarrhea	☐ Epinephrine	☐ Diphenhydramine	☐ Rescue Inhaler
Throat: tightening of throat, hoarseness hacking cough	☐ Epinephrine	☐ Diphenhydramine	☐ Rescue Inhaler
Lung: shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Diphenhydramine	☐ Rescue Inhaler
Heart: weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Diphenhydramine	☐ Rescue Inhaler
Other:	☐ Epinephrine	☐ Diphenhydramine	☐ Rescue Inhaler
If reaction is progressing (several of the above areas affected) give:	☐ Epinephrine	☐ Diphenhydramine	☐ Rescue Inhaler

DOSAGE
Epinephrine: Inject intramuscularly (circle one) EpiPen EpiPen Jr.

Antihistamine: Give: _____
(*Diphenhydramine*) Medication: Amount: Route:

Rescue Inhaler: Give _____
Medication Number of puffs

☐ Student's allergy is potentially life threatening and needs a modification to school lunch ☐ Student needs to eat in separate dining area
☐ Student medication may be secured in the school clinic**.** ☐ Student MUST carry own emergency medication on their person at all times.
☐ Other modification needed_____

Note: 911 will be called immediately when an EpiPen is administered at school. If school nurse is not available EpiPen may be administered by trained unlicensed staff in the school setting.

Physician Signature_____ Date_____