

MEDICAL REVIEW OF STUDENT WITH SEVERE ALLERGIES

Name: _____ Date of Birth: _____
OSIS: _____ Grade: _____ Class: _____ School: _____

CHILD'S MEDICAL PROVIDER TO SUPPLY THE FOLLOWING INFORMATION:

Diagnosis: _____

Specific Allergen(s): _____

Extent of Allergy:

Mild/moderate/severe _____

Exposure route: _____

Clinical symptoms: _____

Respiratory: _____

Skin: _____

GI: _____

Cardiovascular: _____

Neurologic: _____

Other: _____

Previously Documented Anaphylaxis Episode:

Date(s): _____

Physical findings: _____

Treatment: _____

Treatment facility: _____

Hospital name _____

Physician's office/contact information: _____

Home: _____

Other: _____

Tests Documenting Allergy:

Diagnostic Testing/Allergist Evaluation: _____

Date: _____

Physician Name and Contact Information: _____

(attach copy of results)

Medication(s) Requested During School Hours:

(Provider must complete Medication Administration Form)

Child's self-management ability: _____

Ability to recognize/avoid allergens independently: _____

Ability to recognize signs of allergic reaction: _____

Ability to carry/self-administer epi-pen: _____

Child's Medical Provider: _____
Print Name

Signature: _____ Tel.: _____ Date: _____

Reviewed/discussed with provider by School Health Program MD:

_____ Date: _____

Comments:

