ALLERGY INFORMATION FORM
Mayfair Co-Op Preschool

Please complete a separate form for each known allergy

Student's Name _____ Class _____ School Year_____
Parent/Guardian _____ Home #_____Work #_____
Physician_____ Phone# _____
Family member or friend aware of child's condition
Name_____ Phone# _____

My child is at risk for a life-threatening allergic reaction. ____ Yes ____ No

Please list specific allergy: _____

Please check circumstances which reaction could occur:

_____Skin contact _____Ingestion (eating allergen) _____Inhalation (breathing allergen)

My child's allergy was identified through allergy testing. ____Yes ____ No

Date of last reaction: _____

My child had the following symptoms during the reaction: (circle appropriate information)
Red, watery eyes; Shortness of breath; Coughing; Swelling; Nausea/Vomiting;
Runny nose; Tightening of throat; Hives; Dizziness; Other _____

If an allergic reaction would occur at school, personnel will administer first aid (remove stinger, apply ice, observe for 15 minutes and record side effects). You will be notified of the incident immediately.

Please indicate which further treatment a health care provider is recommending for your child:

_____Administer medication – Name and dosage_____

_____Call 911 Immediately _____

_____Other (please attach written instructions)

****Please note that 911 will be called if an Epipen is given or if your child is demonstrating symptoms of a systemic allergic reaction****

I hereby give permission for designated school staff to give this medication to my child according to the directions stated above and to contact my child's physician if necessary.

I further agree to hold harmless Mayfair Co-Op Preschool and all employees and agents who are acting within the scope of their duties in any and all claims arising from the administration of this medication, to policy at school.

I agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

Parent Signature _____Date_____

Physician Signature _____ Date _____