AUBURN UNION SCHOOL DISTRICT
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AUBURN, CA 95603
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ALLERGIC REACTION INFORMATION

Dear Parent/Guardian,

According to your child's health records, he/she has a type of allergy that may result in a severe allergic reaction. To best assist us in anticipating and treating a possible allergic reaction, please complete this form and return it to the district nurse or school health clerk as soon as possible. Thank you!

Student Name:		**DOB:**
School:	**Grade:**	**School Year:**

● **What is your child allergic to?** ☐Peanuts ☐Insect stings ☐Eggs ☐Fish/Shellfish ☐Dairy ☐Tree Nuts ☐Soy ☐Other_______	●**Age of student when allergy first discovered:** ●**Does your child have any other medical issues**? ☐Yes ☐No If yes, please list:
●**If food allergy, does student react after:** ☐Ingesting ☐Touching ☐Smelling	●**How many times has student had a reaction?** ☐Never ☐Once ☐More than once ●**If more than once, are the allergic reactions:** ☐Same ☐Better ☐Worse
●**What symptoms does your child experience:** ☐Hives ☐Itching ☐Flushing ☐Swelling ☐Nausea ☐Vomiting ☐Diarrhea ☐Cough ☐Dizziness ☐Shortness of Breath ☐Throat tightness ☐Loss of consciousness ☐Wheezing ☐Weak Pulse ☐Other	
●**How have past reactions been treated?** ☐Benadryl ☐Epi-Pen ☐Inhaler ☐Other	●**Has you child ever need to go the emergency room or be hospitalized for a reaction?** ☐Yes ☐No If yes, please explain:

•**Does your child need to have emergency medication at school**? ☐Yes ☐No

PLEASE NOTE: A supply of your child's medication may be kept at school (or on your child's person if needed for emergency use), but only if a "<u>Medication At School</u>" or "<u>Allergy Action Plan</u>" form has been completed and submitted to the school health clerk or district nurse.

Signature of Parent/Guardian:________________________________ Date:_________

• FOR HEALTH OFFICE USE ONLY •		
Date Received:	**☐Follow Up Needed**	**☐ISHP Completed**