

PTS ANNUAL ALLERGY UPDATE

Name: _____ Grade: _____
School: _____
Parent/Guardian Name: _____
Phone: (H) _____ (W) _____ (Cell) _____

**** The following information is to be completed and signed by the parents and physician at the beginning of each school year.**

- Identify the items that trigger an allergy episode (Check all that apply)
 Bee/Insect Sting Environmental: _____
 Food: _____
 Other: _____

- Symptoms student has experienced: _____

- Daily/Emergency Medication Plan:
Medication Name(s) & Dosage(s): _____

- Emergency Allergy Medicine: Student to carry medication at all times
 Medication to be kept in clinic

**** If your child requires oral medication or an Epi Pen in school this medication must be brought to the school clinic and a medication permission slip signed by the guardian.**

Release of Information

Dr. _____,
I hereby authorize the release of medical information regarding asthma for my son/daughter _____, date of birth _____. It is my understanding that such information is to be kept confidential and will be used to assist the school in making the necessary health care provisions during the school day.

Parent signature: _____ Date: _____

Current Medical Dx: _____

Current Medications: _____

Activity Restrictions: _____

Physician Signature: _____ Date: _____