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: _____