# 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 <u>physician</u> 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.**

## <u>Release of Information</u>

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: __________________