ST. JOSEPH
CATHOLIC SCHOOL

ALLERGY INFORMATION FORM
2019-2020

Please return this form
Aug. 27th or Aug. 28th

Student's Full Name: _____ Grade: _____

Please choose one:

☐ My child **does not** have a life threatening anaphylactic reaction allergy. Please sign and return this form to the school office.

Parent/Guardian Signature: _____ Date: _____

(No need to complete below document if there is no life threatening allergy.)

☐ My child **has** a life threatening anaphylactic reaction allergy. Please sign and continue filling out the information below. Return this completed form to the school office.

Parent/Guardian Signature: _____ Date: _____

1. Request for (Cows Milk) substitution ☐ Yes ☐ No
2. Check the items that have caused an allergic reaction:
   ☐ Peanuts/Peanut products ☐ Fish/Shellfish ☐ Eggs ☐ Tree Nuts (walnuts, almonds, etc.)
   ☐ Bee Stings ☐ Soy Products ☐ Milk ☐ Tree Nut products (butters/oils, etc.)
   Please list any others:
   _____
3. How many times has your child had a reaction? ☐ Never ☐ Once ☐ more than once
   Please describe: _____
4. When was the last reaction? _____
5. What are the signs and symptoms of your child's allergic reaction? (Please be specific: include things the child might say). _____
6. Does your child have asthma? ☐ Yes ☐ No
7. Has your child ever needed treatment at a clinic or hospital for an allergic reaction? ☐ Yes ☐ No
   If yes, please explain: _____
8. Has your child ever received or used an Epi-Pen or other injection as treatment? ☐ Yes ☐ No
   If yes, please explain: _____
9. Does your child understand how to avoid allergens? ☐ Yes ☐ No
10. What do you do at home if there is an allergic reaction? _____
11. What treatment or medication has your health care provider recommended for an allergic reaction?
    _____ ☐ None
12. Does your child know how to self-administer the treatment or medicine? ☐ Yes ☐ No

PLEASE NOTE: A signed form by parent and doctor (Authorization for Administration of Medication at School) for medications must be provided if medications are required during school hours. Please pick up form at the front desk of the school.

13. Health Care Provider: _____ Phone: _____
14. I give consent to share with the classroom that my child has a life-threatening anaphylactic reaction allergy.
    ☐ Yes ☐ No

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian	Primary Phone	Second Phone	Email address
Emergency Contact			

>>>>If your child has immediate food needs on the second day of school please email the cafeteria staff now so they can be prepared for your student, suzyk@stjoevanschool.org