FOR OFFICE USE: Notified/Copy Given To: Classroom Teacher _____ PE Teacher _____ Other _____
Teacher Initials _____ PE Teacher Initials _____

Dickinson PUBLIC SCHOOLS

Allergy Management Plan and Parent Authorization for Antihistamine (For non-anaphylactic allergies)

Student name	**DOB**	**Grade**
Parent(s)/Guardian(s)	**School/teacher**	
Parent/Guardian Phone Numbers **Home:** **Work:**	**Cell:**	
Emergency Contact (other than Parent/Guardian)	**Emergency contact phone:**	
Physician/Phone	**Hospital/Phone**	

ALLERGIES (*Check all that apply*): _____ **Animals** _____ **Bee/insect stings** _____ **Dust/dust mites** _____
Latex _____ **Molds** _____ **Pollen** _____ **Strong odors/fumes** _____
Foods:_____
Medications:_____
Other:_____

HISTORY

1. Does your child know what allergies he/she has? ☐Yes ☐No
2. Does your child know when to contact an adult for help? ☐Yes ☐No
3. Has your child gone to the emergency room for allergy symptoms? ☐Yes ☐No
4. Has your child had a life threatening anaphylactic allergic reaction? ☐Yes ☐No
5. Is your child treated with an antihistamine? ☐Yes ☐No

SIGNS OF AN ALLERGIC REACTION -- *Circle allergy symptoms your child has had:*

- **Eyes**: red, watery, itchy
- **Nose:** runny, stuff, sneezing
- **Mouth:** itching, swelling of lips, tongue, or mouth
- **Heart:** weak pulse, passing out, increased heart rate
- **Throat:** itching, tightness, hoarseness, hacking cough, difficulty swallowing
- **Skin:** hives, itchy rash, swelling of the face or extremities, or other areas
- **Stomach:** nausea, stomach cramps, vomiting, diarrhea
- **Lungs:** shortness of breath, coughing, wheezing, difficulty breathing

(Continued on Back Side)

WHAT SHOULD SCHOOL STAFF DO TO CARE FOR YOUR CHILD IF HE/SHE SHOWS SIGNS OF AN ALLERGIC REACTION

1. _____
2. _____
3. _____
4. _____

PARENT CARE AUTHORIZATION:

- ◯ I understand that school personnel will make good faith efforts to provide medical care to my child and acknowledge school personnel will not be held legally or financially responsible for this care.
- ◯ I will notify the school immediately of any changes in my child's health status or medication.
- ◯ I give permission to School personnel to contact my child's physician as needed; and that education/health information may be shared with staff who need to know.

Parent/Guardian Signature of Approval (*Required*): _____ **Date:**_____

If your child requires medication for his/her allergy, please fill out the following authorization and bring medication to school. Medication must be in its original container with label attached – small containers preferred.

MEDICATION AUTHORIZATION:

Medication name:_____ **Strength:**_____ **How many:**_____

Instruction for use:_____

Medication side effects:_____

Other information staff should know about student and this medication:_____

_____

As parent/guardian of the above-named child, I give permission to Dickinson Public School personnel to administer the above-named medication to my child; *I also acknowledge school personnel will not be responsible, legally, or financially, for the administration of this medication.*

Parent/Guardian Signature of Approval (*Required*): _____ **Date:** _____

**Form valid for one year from date of signature unless changes in medical status.*