Preschool Food, Insect, and/or Environmental ***Allergy*** Assessment Form

Date: _____ Students Name: _____ Grade: _____

Physician treating allergy: _____ Student's Age: _____

Parent/Guardian: _____ Cell Number: _____

Allergy: _____

Triggers (circle all that apply): EATING TOUCHING SMELLING OTHER:_____

Child's reaction (please be specific): _____

How quickly does the reaction appear (circle one): SECONDS MINUTES HOURS

Plan of action: (Please describe in detail what you would like Parkview Baptist School to do if your child encounters an allergen during school hours.) _____

_____

_____

****A PBS Medication Form needs to be filled out as well for each medication (EpiPen/Benadryl) to be given in case of an allergic reaction during school hours.****

Date of last reaction: _____ Asthma? NO YES

How many times has your child had a reaction? NEVER ONCE MORE THAN ONCE

Does your child understand/know how to avoid their allergen? NO YES

Medication:

Epinephrine (inject into outer thigh): _____EpiPen 0.3mg OR _____EpiPen Jr 0.15mg

Brand Name of Epinephrine: _____

Antihistamine: Benadryl _____mg Other_____

Other: _____

Signature of Parent/Guardian: _____