

Olton ISD Allergy & Anaphylaxis History Form

Student Name:	DOB:	Grade:
Homeroom Teacher:		
Allergies:	Re	action:
(1) Emergency Contact Nam	ne/Number:	
(2) Emergency Contact Nam	ne/Number:	
Physician Name/Number:		
Clinic Address:		
When was your last allergic reac	tion or anaphylactic episode?	
What was the plan of action?	Antihistamine DEpinephrin	ne 🗆 Hospital
What medications are you <u>curre</u>	ntly taking?	
Medication Name	Dose	Frequency
1. Are you knowledgeable ab	out your medication?	Yes No
2. Do you know when you need your medication?		Yes No
3. Does your child require medication at school?		Yes No

- 4. Does your child have an epi-pen?YesNo
- a. If yes, how many pens are available?5. Does your child carry his/her pen at all times? Yes No



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If yes to #3, #4, or #5, the attached *Medication Administration Form* must be completed and returned to the school nurse with the medication. The medication must be in the original labeled container and must always have a current prescription label.

In addition, please thoroughly complete the attached *FARE* form. This will allow the school nurse to complete an IHP (care plan) for your student to ensure that staff is able to provide the best care to your student if and when needed.