Allergy and/or Dietary Restriction Form

Child's Name
Date of Birth

Photo

Health Disclosure
☐Allergy* ☐ Dietary Restriction ☐ Religious Preference
Description of child's special dietary restriction

**** If your child has a known allergy, please have your healthcare provider complete the highlighted sections below.***

Description of Allergy/Condition	
Date of last reaction	Action Taken

Please circle all allergy symptoms child has ever experienced

Mouth	Itching and swelling of lips, tongue or mouth
Throat	Itching and/or sense of tightness in the throat; hoarseness; hacking cough
Skin	Hives; itchy rash and/or swelling around the face, arms, or legs
Stomach	Nausea, abdominal cramps, vomiting, diarrhea
Lung	Shortness of breath; repetitive coughing; wheezing
Heart	"Thready" pulse; passing out

Treatment Plan

Name of Medicine _____

Prescription # _____ **Expiration Date** _____

Location of Medication in Building _____

Dosage Instructions _____

Route of Delivery_____

Emergency Calls

Call 911 – State that an allergic reaction has been treated, and additional emergency may be needed.

Comments

Physician's Stamp

Physician's Signature (required)	**Date**

I hereby request Primrose, through its designated authority, to administer medication according to the above instruction. I release the school and any school employee from any liability for administering this medication.

Parent's Signature	**Date**

Form must be updated annually or anytime information verified by a physician changes.

Child Name: _____

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Year: