Student Name:_____ Date of Birth:_____

Parent/Guardian(s):_____

Home Phone:_____Cell Phone:_____ Work Phone:_____

Daytime Phone:_____ Address:_____

Date:_____

Does your child have any allergies/sensitivities/asthma that may require treatment? ☁ **Yes** ☁ **No**

NO KNOWN ALLERGIES/SENSITIVITIES
My student does not have any known allergies/sensitivities and will not be needing any medication kept at Saint Sophia School. If my child does have an emergency reaction, Saint Sophia School ☁ **has** ☁ **does not** have permission to administer an epi-pen**.**

Parent/Guardian Signature:_____ Date:_____

If there are no known allergies, please fill out and sign the consent above. If yes, please continue to fill out the forms below

Do you think your child's allergies/sensitivities may be life threatening? ☁ **Yes** ☁ **No**

History and Current Status

Please list any allergies or sensitivities to food, environment, medication, etc:

_____

_____

_____

How many times has your student had a reaction?

_____

What did this reaction look like?

_____

_____

_____

Triggers and Symptoms

What has to happen for your student to react to the problem food(s), medication, or environment? (Please circle all that apply)

Eating Touching Smelling Other, please explain:

_____

_____

_____

What are the signs and symptoms of your student's allergic reaction(s)? **(Please be specific; include things the student might say.)**

_____

_____

_____

How quickly do the signs and symptoms appear after exposure?

____ Seconds _____ Minutes _____ Hours _____ Days

Has your student ever needed treatment at a clinic or the hospital for an allergic/sensitivity reaction or asthma? **Yes No If yes, please explain.**

_____

_____

_____

Does your student understand how to avoid foods/medications/environment that cause allergy or sensitivity reactions? ☐ **Yes** ☐ **No**

Treatment

Please list any allergies that may require treatment with an Epinephrine Auto Injector (Epi-pen):

_____

_____

CONSENT TO INFORMATION SHARING AND POSTING

I hereby consent to share that my child has allergies, sensitivities. and/or asthma are with Saint Sophia School faculty, staff, parents and other students. Further, I hereby consent and give my permission to Saint Sophia School to post a written directory listing my child's name including all allergies, sensitivities, and/or asthma in each classroom, lunch room and front office of Saint Sophia School.

Parent/Guardian Signature:_____ Date:_____

EMERGENCY TREATMENT CONSENT

I hereby give my permission and consent to all the administration of an Epinephrine Auto-Injection (Epi-pen), Benadryl or a rescue inhaler by Saint Sophia School's faculty and staff in the event that my child has an emergency allergic reaction/asthma attack while at Saint Sophia School.

List of medication that Saint Sophia School's faculty or staff can administer (please include dosage and how often we can administer medication)

Medication Name:	Medication Dosage:	Instructions:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian Signature:_____ Date:_____