2015 - 2016 **Doris Todd Christian Academy**

ALLERGY TREATMENT FORM

One Form per Student – Please Print Clearly

Student's Full Legal Name_____ Date of Birth _____
Last First Middle

Parent(s) or Guardian(s) Name:_____Contact #:_____

Health Provider:_____ Emergency:_____

Specialist's Name(if any):_____Phone Number:_____

Description of Allergy:_____

_____

When to contact parent or healthcare provider regarding symptoms or failure to respond to treatment:_____

_____

If I am unable to be contacted, Doris Todd Christian Academy staff has my permission for_____
to receive emergency care at a hospital or emergency center. **Student's Name**

Signature of Parent or Guardian_____ Date:_____

Signs/Symptoms of Allergic Reaction (mark all that apply)

___Itching ___Trouble breathing, swallowing or talking ___Abdominal pain, diarrhea

___Hives ___Swelling or redness ___Dizziness, lightheadedness or fainting

___Vomiting ___Itching/Swelling of tongue, lips or mouth ___Wheezing, nasal congestion

___Rash ___Other(specify):_____

Severity of allergies (circle one)

Not Severe 1 2 3 4 5 Severe

Describe known triggers:_____

_____

Describe treatment:_____

_____

Possible side effects of treatment: _____

_____

Physician's Name:_____**Date**:_____

Physician's Signature:_____