

Authorization for Emergency Care Of Children with Severe Allergies

This information pertains to the 20____ - 20____ academic year.

Dear Health Care Provider,

Your patient, _____ is enrolled in [INSERT SCHOOL NAME] and we have been requested to provide certain emergency care for the prevention of anaphylaxis in the event the child comes into contact with a certain allergen(s), as described below. Please complete Part I of this instruction record. This record will remain in the child's file at [INSERT SCHOOL NAME] so we may assist with the allergy care and needs of the child. If you need to provide further instructions or clarifications, please do so on a separate sheet of paper, which will become a part of this record and will be kept with this form in the child's file at [INSERT SCHOOL NAME].

PART I (to be completed by a Licensed Health Care Provider)

Child's Name: _____ Child's Birth Date: _____

Known Allergens: (Please provide a complete list of all events and/or substances that may trigger a severe allergic reaction (i.e. Anaphylactic shock) in the child.)

- _____ Bee Sting
- _____ Other Insect Bite(s): (identify): _____
- _____ Animal(s): (identify): _____
- _____ Food Allergy: (identify all foods or groups of foods that must be avoided): _____
- _____ Other: (identify): _____

SYMPTOMS: (Please provide a complete list of all symptoms that indicate the child has come into contact with an allergen and requires emergency treatment.)

- _____ Shortness of Breath _____ Swelling of the Face or Lips _____ Diarrhea
 - _____ Hives _____ Vomiting
 - _____ Other: (explain): _____
- _____