Downingtown Area School District
Allergic Reaction Form

Student_____

School_____Teacher/Grade_____

It has been noted on your child's health records that he/she has an allergic reaction to_____

Please take the time to update our records by completing this form. Check the items below that are applicable to your child.
My child is allergic to _____

Symptoms student has experienced in the past: (please check all that apply)

_____ localized swelling _____ Swelling of lips. Tongue throat _____ Hives
_____Wheezing _____ Hoarseness _____Breathing diff.
_____ Dizziness _____ Thickened speech _____Nausea
_____Weakness _____ Abdominal cramps _____Itching all over
_____Blue color of lips or skin _____skin flushed all over body
_____ Other (explain) _____

_____ Please give _____
Name of medication and amount to be given must be listed

Any required medication is to be sent into school along with your doctor's signature. Medication must be in the original container and properly marked with the child's name and directions for administering. Medication cannot be given by health room personnel if medication is not sent from home or the appropriate signatures are not on file.

Additional comments or instructions:
_____
_____

_____ My child is no longer allergic to : _____

_____ _____( )_____
Date Parent Signature Phone

_____ _____( )_____
Date Physician's Signature Phone
(Required for medication administration)