HISTORY OF SEVERE ALLERGIC REACTIONS

What is your child severely allergic to? When was the last reaction? How many reactions has your child had?	What **has happened** in the past when your child has a reaction? ☐ Facial swelling ☐ Throat swelling ☐ Hives or rash ☐ Difficulty breathing or swallowing ☐ Hoarseness ☐ Burning sensation ☐ Changes in skin color ☐ Seezing/wheezing/coughing ☐ Abdominal pain ☐ Nausea/ vomiting/ diarrhea ☐ Other (describe below:) _____ _____
Has your child needed emergency treatment or had to be hospitalized because of severe allergic reaction? ☐Yes ☐ No	How has your child reacted to their allergen in the past? ☐ Contact ☐ Inhaling ☐ Ingesting ☐ Sting
How has the reaction been treated in the past? (medication name(s), dose and frequency)	Does your child also have *mild allergies*? ☐Yes ☐ No What is used to control your child's allergies?
Who is your child's allergist? (name and contact info)	Does your child also have *asthma*? ☐ Yes ☐ No What is used to control your child's asthma?
<u>List of medications taken on a daily or routine basis (include name, dose and frequency)</u>	
Is there anything else that is important to know about your child's health	

MOLALLA RIVER SCHOOL DISTRICT

Student name: _____

Date of birth: _____

Parent signature: _____

Date: _____