NORWALK PUBLIC SCHOOLS
SCHOOL HEALTH SRVICES

LIFE-THREATENING ALLERGY INFORMATION SHEET
(FOOD, INSECT, LATEX)

Please complete the following information specific to your child's needs and return to the School Nurse.

Student's Name:______________________________ Grade:________________

Physician's Name:______________________________ Telephone#:_____________

Student's Health Problems:____

Asthma: Yes______ No_____

Please provide information describing your child's allergy to **each** food, insect, or other allergen. Be as specific as possible.

Food/Insect/Other Allergen____
Check signs usually present during an attack:

_____difficulty breathing
_____wheezing or coughing
_____difficulty swallowing
_____swelling WHERE? __________
_____dizziness
_____flushed or pale
_____nausea, vomiting, cramps, diarrhea
_____itching WHERE? _________
_____rash or hives WHERE? _________

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_____rash or hives WHERE? _________

Has hospitalization or other medical treatment been needed in the past for allergies?
Yes____ No____ If yes, when?____
Please desccribe____

Please have the attached medication authorization form(s) completed by the student's physician and parent/guardian. Return the authorization to school with the needed medication. All medications must be in the original container with pharmacy label and brought in by parent/guardian.

________________________________ ______________
Signature of parent/guardian **Date**