Post Falls School District #273
School Nursing Services
206 W. Mullan Ave, Post Falls ID 83854
PO Box 40, Post Falls, ID 83877
(208) 773-6976

Allergy Information

Dear Parent/Guardian:

If your child has an allergy or allergies, please complete this form and return it to your child's school.

Student's Name: ____
School: ________________________________ Grade: ____________ Teacher: _____________________________________
Parent/Guardian: ____Phone: ______________________
Physician's Name: ____ Phone: ______________________

1. Please list all of your child's allergies: ____
____
2. How long has your child had these allergies:____
3. Check the type of reaction your child has had in the past.

☐ Hives/rash ☐ Tired/Weak ☐ Difficulty breathing/coughing ☐ Tightness/Swelling in throat
☐ Loss of consciousness ☐ Abdominal Discomfort ☐ Vomiting/Diarrhea ☐ Itching/Tingling
☐ Swelling (description): ____
☐ Other: ____

4. Does your child take medication for allergies? ☐ Yes ☐ No ☐ Not currently

Please list all medications related to allergy, prescribed or over the counter:

Epi-pen/Epinephrine Prescribed?	Other Medications	Dose/Time	Side Effects
☐ Yes ☐ No			

If your child needs to take medication at school, please bring the medication to the school office in the original container (an extra prescription bottle may be prepared for school at the pharmacy).

*An **Authorization for Medication Administration** form will need to be completed. *

5. If you child has a food allergy there is also a **Meal Accommodation** form for food services, if needed.

6. If the school nurse has more questions regarding this form what is your preferred method of contact?
☐ Phone or ☐ Email: ____

Parent/Guardian's signature: ____ Date: ________________

Thank you,
Elizabeth Costin, BSN, RN
Post Falls School District Lead Nurse

Revised: June 2020