Emergency Allergy Alert Form
Anaphylactic Reactions

Name:_____ Classroom_____

Address:_____

Home Telephone #_____

Mother/Guardian_____ Work #_____

Father/Guardian_____Work #_____

Emergency Contact_____ Phone #_____
(In case of emergency – other than parent/guardian)

Doctor's Name_____ Phone #_____

Allergy Description
This student has a **DANGEROUS, life-threatening** allergy to the following:

Foods:	Medications:	Insect Stings	Other

Possible Symptoms: (circle)

- Flushed Face, hives, swelling or itchy lips, tongue, eyes
- Tightness in throat, mouth, chest
- Difficulty breathing or swallowing, wheezing, coughing, choking
- Vomiting, nausea, diarrhea, stomach pains
- Dizziness, unsteadiness, sudden fatigue, rapid heartbeat
- Loss of consciousness

Other
_____
_____
_____
_____
_____

Action – Personal Emergency Plan
_____
_____
_____
_____

EpiPen
EpiPen is kept:
_____
_____
_____