POTTSGROVE SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT

Attention: Parents and Guardians:

You have indicated that your child, _____
has an allergic reaction to _____. The severity of the reaction may vary from person to person. It is our goal to prevent reactions, but should one occur, we want to recognize early signs of a reaction in your child and provide proper care.

PLEASE DO THE FOLLOWING:

1. **Complete the bottom portion of this form.**
2. **Have your physician complete the attached medication administration form.**
3. **If the physician wants your child to carry and self-administer the medication, please have the physician indicate so on the medication form. Then, complete the enclosed Self Administration Checklist.**
4. **Complete the Emergency Care Plan.**
5. **Sign and Return Roles and Responsibilities for Severe Allergies.**

If you have any questions, please contact your child's School Nurse. By working together, we can best provide for the health and safety of your child.

School Nurse: _____
School: _____

PLEASE NOTE: We cannot be held liable if you fail to respond to this letter or fail to provide necessary medication.

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ALLERGIC REACTION

Child's Name_____Date_____
Have you consulted a physician about this allergy? Yes _____ No_____
Is medication prescribed? Yes ____ No _____
If yes, please have MD complete Medication Forms included in this packet.
Describe exactly what occurs when your child has an allergic reaction:
_____

Which type of **exposure** causes a reaction for your child? (Circle all that apply.)
STING INGESTION TACTILE/TOUCH AIRBORNE

What treatment is required? _____

_____ _____
PARENT SIGNATURE DATE