GARLAND INDEPENDENT SCHOOL DISTRICT
Health Services

Health Update Information
Allergies

To the Parents of:

Date ____________
ID# ____________
DOB ____________
Gr/Tcr ____________

Parent(s) Name: ______________________________
____

Home Phone ____________
Work Phone ____________
Cell Phone ____________
____

Physician's Name ______________________________ Office Phone ____________

What type of allergies does your child have?

☐ Medications (please list) ____________

☐ Food(s) (please list) ____________

☐ Seasonal (pollen, etc.) ____________

☐ Other(s) (please list) ______________________________

Describe the reaction your child has: ______________________________

____

List the names of medications taken **daily** (or regularly) for allergies including dosage and frequency: ____________

____

List the names of medications taken **as needed** for allergies including dosage and frequency: ____________

____

Side effects of medication: ______________________________

Does your child need to take allergy medication at school (even if only on an as needed basis)? ☐ Yes ☐ No

If yes, a properly labeled prescription container and written parent permission are required. Forms are available from the school nurse.

If your child requires the use of an epinephrine auto-injector (EpiPen or TwinJect) for allergy emergencies at school, please contact the school nurse for the appropriate forms to be completed by your child's physician.

Is there anything else you would like for the school nurse to know about your child's allergies? ____________

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PLEASE RETURN TO THE SCHOOL NURSE