WATERFORD PUBLIC SCHOOLS

Addendum to Medical School Form
Anaphylaxis (Severe Allergic Reaction to Bee Stings, Food Allergies, etc.)

Student's Name _____ School _____

Address: _____ Date of Birth _____

Physician's Name _____ Physician # _____

Diagnosis _____

Specific Allergen _____

If student ingests or thinks ingested the above-named allergen --

_____ Observe patient for symptoms of anaphylaxis**

_____ Administer Epinephrine (Epi pen) before symptoms occur

_____ Administer Epinephrine (Epi pen) if symptoms occur

_____ Administer Benadryl _____ (dosage) or Atarax _____ (dosage)

_____ Transport to ER for observation if symptoms occur

_____ _____
Physician Signature Date

SYMPTOMS

Chest tightness, cough, shortness of breath	Hives or Hoarseness
Tightness in throat, difficulty swallowing	Stomach cramps, vomiting, or diarrhea
Swelling of lips, tongue, throat	Dizziness or faintness
Itching Mouth	

I have read and understand the above information.

_____ _____
Parent Signature Date

To be completed at the beginning of each school year or at initial registration.

4/94