Allergies and Anaphylaxis Medical Information Form

Barley Fields Primary School

Child's Name: _____ DOB: _____

Date of information shared: _____

1. **Nature of Allergy**

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2. **Severity of Allergy**

☐ Mild (no prescribed medication in school)

☐ Medium (prescribed medication in school)

☐ Severe (urgent medical treatment/medication required

3. **Symptoms of your child's Allergic Reaction**

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4. What emergency medication must your child carry /have access to in school to be used in the event of an allergic reaction/anaphylactic shock?

☐Inhaler – medication name and dose

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☐Antihistamine medicine or tablet – medication name and dose

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☐ Epipen or Jext medication name and dose

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5. Precautions to be taken to avoid Allergic Reaction

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☐I give permission for my child's prescribed medication to be administered under the supervision of a member of school staff during the school day.

☐I will ensure all prescribed medication kept in school is within expiry dates and clearly labelled with the name and dose.

Signed ..... (parent/guardian)

Emergency Telephone Number .....