

I. T. Montgomery Elementary School
Wellness Committee
202 Martin Luther King, Jr. Road
Mound Bayou, MS 38762-0901
Telephone (662) 741-2433/Fax (662) 741-2578

PARENT'S STATEMENT OF STUDENT'S ALLERGY SEVERITY

Student's Name _____ .D.O.B. _____

ALLERGENS/TRIGGERS (WHAT CHILD IS ALLERGIC TO)

SYMPTOMS THEY CAUSE (SEE LIST BELOW)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Symptoms (itching, rash, hives, local swelling at site; swelling of lips, tongue, eye lids or nose; throat itching or fullness/swelling; voice changes, tingling around mouth or face, nasal congestion, wheezing, feeling of apprehension, weakness, passing out, breathing problems, other anaphylactic severe life threatening symptoms like low blood pressure with weak, rapid pulse; loss of consciousness, shock, coma)

Is Emergency medication required for student when exposed to any of the above? _____ No _____ Yes

(If yes, complete and sign parent/guardian's section of forms and take forms to student's healthcare provider to complete and sign physician's section) Return completed forms ,along with properly labeled emergency medication, in the original container or box, Preferably to school nurse (room # 20 at I.T.M.) or Office Clerk at I.T.M. Elementary School and to Office Clerk at JFK High School) when nurse is absent.

PARENT/GUARDIAN'S DISCLAIMER STATEMENT OF ALLERGY SEVERITY

_____ My child/student's allergic reaction symptoms have not been bad enough to require emergency medication in the past. No emergency medication such as Epi-Pen/Epi-Pen JR has been recommended or ordered by their healthcare provider.

Parent/Guardian's Printed Name

Parent/Guardian's Signature

Date: _____