Shmuel Zahavy Cheder Chabad

Place Student's Current picture here

STUDENT INFORMATION

Student's Name:_____ Date of Birth:_____

Grade:_____

ALLERGY INFORMATION

Asthmatic: ☐ YES ☐ NO

High Risk for Severe Reaction: ☐ YES ☐ NO

Epinephrine Auto-Injector (e.g. Epi-pen): ☐ YES → Expiry Date: _____ / _____ ☐ NO

Location of Auto-Injector(s):_____

ALLEGRIC TO →

(Check the appropriate boxes.)

- ☐ Peanut
- ☐ Tree nuts
- ☐ Egg
- ☐ Milk
- ☐ Other: _____
- ☐ Insect stings
- ☐ Latex
- ☐ Medication:_____

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Skin system: hives, swelling, itching, warmth, redness, rash

Respiratory system (breathing): coughing, wheezing, shortness of breath, chest pain/tightness, throat tightness, hoarse voice, nasal congestion or hay fever-like symptoms (runny, itchy nose and watery eyes, sneezing), trouble swallowing

Gastrointestinal system (stomach): nausea, pain/cramps, vomiting, diarrhea

Cardiovascular system (heart): pale/blue colour, weak pulse, passing out, dizzy/lightheaded, shock

Other: anxiety, feeling of "impending doom", headache, uterine cramps, metallic taste

Early recognition of symptoms and immediate treatment could save a person's life.

ACTION PLAN:

Give _____at the first sign of a known or suspected anaphylactic reaction

Call Rescue Squad: ☐ Hatzoloh (416-256-1000) ☐ 9-1-1 ☐ Other(s):_____

	Name	Home Phone	Work Phone	Cell Phone
Mother				
Father				
Doctor				

EMERGENCY CONTACTS:

Priority	Name	Relationship	Phone #
1)			
2)			

The undersigned parent authorizes any adult to administer epinephrine to the above-named person in the event of an anaphylactic reaction, as described above.

_____ _____ _____ _____

Parent Signature Date Physician Signature Date