Ira Independent School District

Allergy without anaphylaxis

(Food or other allergy requiring treatment or special consideration at school)

Student Name: _____ DOB: ___/___/___

Parents/Guardians caring for child: _____

Home phone: _____

List allergy:		Type (topical, ingestion, etc):		
Symptoms and reaction that occurs:				
Special instructions/considerations for school (including food substitutions):				
Does student take medication at home?				
Will student need medication while at school?				
MEDICATION				
Medication at home:				
Name of medication	Dose	Frequency	Time of day	Special instructions
Medication at school:				
Name of medication	Dose	Frequency	Time of day	Special instructions

Please provide any other information that may be needed for the school/school nurse regarding this allergy.

_____ _____

Physician signature Date