NYC Department of Education
Chancellor Richard A. Carranza

MEDICAL REVIEW OF STUDENT WITH SEVERE ALLERGIES

Name: ______________________________________ Date of Birth: ________________________

OSIS: _____________________ Grade: ___________ Class: _________ School: _____________

CHILD'S MEDICAL PROVIDER TO SUPPLY THE FOLLOWING INFORMATION:

Diagnosis: ____

Specific Allergen(s): ____

Extent of Allergy

Mild/moderate/severe ____

Exposure route: ____

Clinical symptoms: ____

Respiratory: ____

Skin: ____

GI: ____

Cardiovascular: ____

Neurologic: ____

Other: ____

Previously Documented Anaphylaxis Episode

Date(s): ____

Physical findings: ____

Treatment: ____

Treatment facility: ____

Hospital name: ____

Physician's office/contact information: __________________________________

Home: ____

Other: ____

Tests Documenting Allergy

Diagnostic Testing/Allergist Evaluation: ______________________________

Date: ______________________________

Physician Name and Contact Information: ______________________________

(attach copy of results)

Medication(s) Requested During School Hours

(Provider must complete Medication Administration Form)

Child's self-management ability: ______________________________

Ability to recognize/avoid allergens independently: ______________________________

Ability to recognize signs of allergic reaction: ______________________________

Ability to carry/self-administer epi-pen: ______________________________

Names and Signatures

Child's Medical Provider (print name): ______________________________

Signature: ____________________ Tel.: ________________ Date: __________

Reviewed/discussed with provider by School Health Program MD:

______________________________ Date: ______________

Comments:

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