



**Lake Forest School District 67  
Authorization for Emergency Care  
of Students with Allergies**

**Dear Doctor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Your patient, \_\_\_\_\_, is enrolled in Lake Forest School District 67, and we have been requested to provide certain emergency care in the event that the child comes into contact with a certain allergen(s) as described below. Please complete this form, describing the treatment needed for the allergy described. This will become a part of the child's health file at school.

**To be completed by physician:**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**Allergens:**

Please provide a complete list of all substances that may trigger an allergic reaction in the child.

\_\_\_\_\_ Bee Sting

\_\_\_\_\_ Other Insect Bite: (Identify) \_\_\_\_\_

\_\_\_\_\_ Animal: (Identify) \_\_\_\_\_

\_\_\_\_\_ Food Allergy: (Identify all foods that must be avoided) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Other: (Identify) \_\_\_\_\_

**Symptoms:**

Please provide a complete list of all symptoms that indicate that the child has come into contact with an allergen and that he/she requires emergency treatment.

\_\_\_\_\_ Shortness of breath or difficulty breathing

\_\_\_\_\_ Swelling of the face or lips

\_\_\_\_\_ Hives

\_\_\_\_\_ Vomiting

\_\_\_\_\_ Diarrhea

\_\_\_\_\_ Other: (Explain) \_\_\_\_\_

\_\_\_\_\_ Do not administer medication in the absence of known exposure to the allergen (Explain):

\_\_\_\_\_

**Procedures:**

Please number all steps necessary in the order in which they should be taken:

\_\_\_\_\_ Give Benadryl orally for symptoms of: \_\_\_\_\_

\_\_\_\_\_ Administer Epinephine Auto-Injector for symptoms of: \_\_\_\_\_

\_\_\_\_\_ Call 911

\_\_\_\_\_ Call parent/guardian: \_\_\_\_\_

\_\_\_\_\_ Call child's physician: \_\_\_\_\_

\_\_\_\_\_ Other (Explain): \_\_\_\_\_

\_\_\_\_\_ No treatment required

**Child's Physician:**

Name (Print): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_