SHEPHERD of the HILLS Homeschool Co-Op

Authorization for Emergency Care of Children with Severe Allergies

If emergency treatment includes the administration of epinephrine or any other prescription medication, this form must be completed and signed by the child's physician.

Child's Name _____ Child's Birth Date _____

Allergens:
Provide a complete list of all events and/or substances that may trigger a severe allergic reaction in the child.
_____ Bee Sting
_____ Other Insect (Identify) _____
_____ Animal Fur or Dander (Identify) _____
_____ Food Allergies (Identify all foods to avoid) _____
_____ NA

Symptoms:
Provide a complete list of all symptoms that indicate that the child has come in contact with an allergen and that he or she requires emergency treatment.
_____ Shortness of breath or difficulty breathing
_____ Swelling of the face or lips
_____ Other
(Explain) _____
_____ Hives
_____ Vomiting
_____ Diarrhea

Procedures:
Indicate all steps necessary and the order in which they should be taken.

1) _____
2) _____
3) _____
4) _____
5) _____

Recreational Activities
The child may participate in recreational activities. [ ] Yes [ ] No
Activity Restrictions: [ ] None [ ] Some restrictions
(Explain)_____

By signing this form, I authorize Shepherd of the Hills to follow the above instructions in this Authorization Form. I agree to update this form every six months or sooner if my child's needs change.

Parent Name (Please print) _____

Parent Signature _____ Date _____

Revised August 2020