SEVERE ALLERGIES RESOURCE PACKAGE - SEVERE ALLERGY ALERT FORM

STUDENT INFORMATION (To be completed by Parent or Guardian)

Student Name | **Date of Birth**

Address | **Home Telephone Number**

Medic Alert ID

Parent Name | **Daytime/Business Telephone Number**

Emergency Contact Person(s) | **Telephone Number**

PHYSICIAN INFORMATION (To be completed by Physician)

Nature of Allergy/Allergen:

Symptoms of Reaction:

Recommended Response to Reaction:

Medication: **Dosage:**

Medication: **Dosage:**

Additional Instructions or Information:

Name of Physician | **Telephone Number**

Signature of Physician | **Date**

The personal information collected on this form is necessary for determining eligibility for an education program and is collected in accordance with the Freedom of Information and Protection of Privacy (FOIP) Act, Section 33. The purpose of this collection is to respond to potential emergency situations involving your student whom you have identified as subject to a potentially life-threatening allergy. If you have any questions about the collection, use and disclosure of the personal information on this form, please contact the school principal or HPSD's FOIP Coordinator @ 780-523-3337.