

Student Allergy Form

FVAC Summer Arts Adventures 20__

Student Name: _____

Student Address: _____

Allergic to: _____

Previous reactions caused by (circle all that apply) **Ingestion, Airborne Exposure, Skin Contact**

Previous reaction symptoms included: _____

The student is _____ **not at high risk**

_____ **is at high risk for experiencing an Anaphylactic/Life threatening reaction**

due to: _____ previous anaphylactic reaction

_____ Asthmatic

_____ Other: _____

Do this immediately:

_____ Give medication (**yes/no**)

_____ Name of medication

_____ Method of use

_____ Specific location of medicine

Call for medical emergency help at: _____

Other notes: _____
