The Little House (Montessori)®

Child Medical Form

Child's Photo

*Child's Name:*_____*DOB*_____*Child's BC No.* _____

(1) ALLERGY TO: _____

*Asthmatic Yes** ☐ *No* ☐ ** Higher risk for severe reaction*

Treatment

Symptoms:	*Give Checked Medication** ** To be determined by physician authorizing treatment)*
▪ *If a food allergen has been ingested, but no symptoms:*	☐ *Epinephrine* ☐ *Antihistamine*
▪ *Mouth (Itching, tingling, or swelling of lips, tongue, mouth)*	☐ *Epinephrine* ☐ *Antihistamine*
▪ *Skin (Hives, itchy rash, swelling of the face or extremities)*	☐ *Epinephrine* ☐ *Antihistamine*
▪ *Gut (Nausea, abdominal cramps, vomiting, diarrhea)*	☐ *Epinephrine* ☐ *Antihistamine*
▪ *Throat † (Tightening of throat, hoarseness, hacking cough)*	☐ *Epinephrine* ☐ *Antihistamine*
▪ *Lung † (Shortness of breath, repetitive coughing, wheezing)*	☐ *Epinephrine* ☐ *Antihistamine*
▪ *Heart † (Weak of thready pulse, low blood pressure, fainting, pale blueness)*	☐ *Epinephrine* ☐ *Antihistamine*
▪ *Other †* _____	☐ *Epinephrine* ☐ *Antihistamine*
▪ *If reaction is progressing (several of the above areas affected), give:*	☐ *Epinephrine* ☐ *Antihistamine*

† Potentially life-threatening. The severity of symptoms can quickly change.

(2) Emergency Calls

1. *Dr.* _____ *Phone Number:* _____
2. *Parent* _____ *Phone Number(s):* _____
3. *Emergency contacts:*

Name/Relationship	*Phone Number(s)*	
a. _____	*1.* _____	*2.* _____
b. _____	*1.* _____	*2.* _____

(3) Medication/Long Term Medication

Epinephrine: inject intramuscularly (Tick one)

☐*Epipen®* ☐*Epipen® Jr.* ☐*Twinject® 0.3mg* ☐*Twinject® 0.15mg*

Anitihistamine: give _____
medication/dose/route

*Other: give*_____
medication/dose/route

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY IF REACTION IS EXTREMELY STRONG!

Parent/Guardian's Signature _____ *Date*_____

Doctor's Signature _____ *Date* _____