Seasonal Allergy Care Plan

Child's Name: _____ DOB: _____

Grade: _____ Homeroom: _____

Parent's Name: _____

My child has seasonal allergies. ____ YES

My child is being treated for seasonal allergies by an allergist. ____ YES ____ NO

Allergy Doctor: _____

My child is allergic to:

_____
_____
_____
_____
_____

Symptoms my child may exhibit during allergy flare up:

_____
_____
_____
_____
_____
_____

Medication taken for allergies:

Medication	Dose	Frequency

*If allergy medication is needed at school, please fill out a **Medication Authorization Form** and email to awidener@silverdaleba.org or fax to 423.892.2147.
*If any of the above information changes, please notify the school nurse.

Parent/Guardian Signature: _____ Date: _____