Allergy Information Form

CHILD INFORMATION:____

Last Name First Name Birthdate (mm/dd/yyyy)

PARENT OR GUARDIAN:____

Last Name First Name Phone Number (xxx-xxx-xxxx)

PHYSICIAN:____

Name Phone Number (xxx-xxx-xxxx)

____

Address City State Zip Code

1. Please indicate items your child has an allergy to:

- Peanut / Peanut Products
- Soy Products
- Other (please indicate):____
- Fish / Shellfish
- Gluten
- Eggs
- Nuts
- Milk
- Bee Stings

____

2. What things trigger an allergic reaction in your child?

____

3. What thing should be avoided due to the allergy?

____

4. What are the sign and symptoms of your child's allergic reaction? Be specific.

____

5. What treatment or medication does your child have in the event of an allergic reaction? (include doses):

____

6. What are the procedures for responding if your child has an allergic reaction?

____

______________________________ ______________________________

Signature of Parent / Guardian Date **Signature of Physician Date**