Child Allergy Information Form

PLEASE PRINT: Complete one form for each child.

CHILD INFORMATION

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

PARENT OR GUARDIAN

Last Name	First Name	Phone No.

PHYSICIAN

Physician's Name	Physician's Number

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

Peanut / Peanut Products	Fish / Shellfish	Eggs	Milk
Soy Products	Gluten	Nuts	Bee Stings

Other (please indicate): _____

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

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

4. What are the signs 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
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