Allergy Information Form

Child's Name: _____ Date: _____

Does your child have allergies? _____ Asthma? _____

Foods _____ which Ones? _____

Pollen _____ what kinds? _____

Molds _____ what kinds? _____

Animals _____ which ones? _____

Dust _____ Other _____

What kind of allergic reaction does your child have? Be specific:

_____

_____

What medication is your child on for his/her allergies?

_____

_____

When is this given? _____

List *any* medication your child is <u>now</u> taking:

_____

_____

Special Instructions/Additional Comments:

_____

_____

Does your child have any special dietary needs and/or restrictions?

_____

_____

_____

Signature