

# ALLERGY FORM



Please complete one form per child.

My child: \_\_\_\_\_

	Allergy	severe	mild	if FOOD allergy:	ingested	contact	order of actions to be taken, including meds *
1		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
2		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
3		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
4		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

**\*Medications Need To Be Listed On a Medication Form & Included With This Form.**

**Please list below, in order of importance, people to contact in case of an emergency due to your child's allergies. This will only happen if the reaction is MILD enough to NOT call 911.**

	Contact Name	Phone #
1		
2		

Parent/Guardian, (name) \_\_\_\_\_ Date: \_\_\_\_\_