

ALLERGY FORM



Please complete 1 (one) form per child.

My Child: _____

Allergy	Severe	Mild	For food allergies, please indicate if allergy is from ingestion or/and contact in next column(s).	Ingested	Contact	Order of actions to be taken, including medications	

Dietary restrictions: _____

If dietary restriction is due to allergy, please list in the above table.

***Medications to be administered 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.

	Name	Phone #
1		
2		

Parent/Guardian Name: _____ Date: _____