

Allergy Form

Child's Name: _____ Date of Birth: _____

Please list any allergies (including food/medication):

Please list any medical conditions:

Symptoms: _____

Procedure to follow: _____

Medication: _____

Note: Staff can only administer prescribed antibiotics or inhalers. Your child may not self-administer any kind of medication nor bring it in his/her backpack.

When to call parent: _____

When to call 911: _____

Emergency Numbers: _____

Physician's Name: _____ Physician's Number: _____

My child has an:

Epinephrine Auto-Injector (EpiPen)

Nebulizer

Inhaler

Staff must be trained to use your child's EpiPen, Nebulizer, or inhaler.

Parent's Signature: _____ Date: _____

*** Please note, we are **not** a peanut-free school***