Allergy Information Sheet

Child's photo

Child's Name: _____ Birth Date: _____

Teacher: _____ Classroom: _____

Does he/she have an EPI pen? YES NO
If yes, see office for additional paperwork.

Please list all allergies (Food, Medication, Insects, etc.)	**Reaction** (Symptoms, Date)
1. _____	1._____
2. _____	2._____
3. _____	3._____
4. _____	4._____

Any Medication used on a daily basis please include doses

1. _____
2. _____
3. _____

Please list in detail any diet restrictions: _____

_____

Emergency Contact Information

Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Alternate Person if Parent cannot be reached:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Parent/Guardian Signature: _____ Date: _____