Mild Allergy & Food Sensitivity Information

Name: ______________________________ Birth Date: _____________

Center/School________________________ Classroom/ Teacher ______________

Please list all allergies (Food, Medication, Insects, etc.)	**Reactions** (Symptoms, Date)
1. ______________________________	1.________________
2. ______________________________	2.________________
3. ______________________________	3.________________
4. ______________________________	4.________________

List any MEDICATIONS used for this allergy. *If "emergency" medications are used (i.e. Epinephrine- EpiPen or others) the **SEVERE ALLERGY care plan** must be filled out*

1. ____
2. ____
3. ____

Please list in detail any DIET restrictions:

____

____

Any other information that would be helpful:

____

____

____

Emergency Contact Information

Parent/Guardian Name: ____

Address: ____

City: ___________________________ State: ______________ Zip: _________

Home #: _______________ Work #: _______________ Cell #: ______________

Parent/Guardian Signature: __________________________ Date: _______________

Nurse Consultant Review:________________________

TCC 2013