

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: _____