



Child's Allergy Form

Child's Name: _____

Child's allergies include: _____

Is this allergy serious or life-threatening? *Yes* or *No*

Reactions to this allergy include: _____

Is any medication currently being used to treat this allergy? *Yes* or *No*
If so, list medication name, dosage and frequency here:

Is the use of an Epi-Pen necessary? *Yes* or *No*
(If one is needed, we will need one kept here labeled with the child's name)

If a reaction were to occur, necessary steps include: _____

Numbers to call:

Parents' Cell: (____) _____ - _____ (____) _____ - _____

Child's Doctor: (____) _____ - _____

If the child ever stops breathing, *we will immediately call 911.*

Parent Signature

Date