ALLERGIES AND MEDICATIONS

Child's Name:	**D.O.B.**	**Age:**
_____	_____	_____

Allergies:

Plants___ Animals____ Food____ Mold____ Drugs____ Bees____ Other____

Please describe the allergic reaction and the treatment for **each** checked allergy:

_____

Check the foods that have caused an allergic reaction:

___ Peanuts
___ Peanut or nut butter
___ Peanut or nut oils
___ Fish/Shellfish
___ Soy Products
___ Tree nuts (walnuts, almonds, pecans, etc.)
___ Eggs
___ Milk
___ Other (Specify)

Please list any others:

_____

Triggers and Symptoms

What has to happen for your child to react to the problem food(s)?
(*Check all that apply*)

___ Eating foods
___ Touching foods
___ Smelling foods
___ Other, please explain:

_____

What are the signs and symptoms of your child's allergic reaction? (*Be specific – include things the child might say*.) _____

_____

How quickly do the signs and symptoms appear after exposure to the foods(s)?
(*Circle one*)

Seconds Minutes Hours Days

How many times has your child had a reaction? ___ Never ___ Once ___ More than once,

explain: _____
When was the last reaction? _____

Are the food allergy reactions: ___Staying the same ___Getting worse ___Getting better

Treatment

Has your child ever needed treatment at a clinic or the hospital for an allergic reaction?
___ No ___ Yes, explain

_____

_____

What treatment or medication has your health care provider recommended for use in an allergic reaction? _____

_____

_____

Have you used the treatment? ___ No ___ Yes
Is the treatment self-administered ___ No ___ Yes

PLEASE NOTE: If Yes, please complete the "Medical Self-Administration" Form.

Please print name of Parent/Guardian: _____

Signature: _____ Date: _____