



## Allergy Form

Child's Name: \_\_\_\_\_

Allergy: \_\_\_\_\_

Medical Condition: \_\_\_\_\_

Symptoms:

Procedure to Follow:

Medication:

When to Call Parent: \_\_\_\_\_

When to Call 911: \_\_\_\_\_

Emergency Numbers: \_\_\_\_\_

Hospital or Specific Doctor: \_\_\_\_\_

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Parent Signature and Date

