



## Allergy Form

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

Date of Birth: \_\_\_\_\_

Please list any of your child's allergies and any medical conditions that your child may have.

Food: \_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

Enviromental: \_\_\_\_\_

\_\_\_\_\_

Any other substance that may cause an allergic reaction:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If my child has an allergy, I authorize that my child's name may be posted in the classroom as a reminder to staff to prevent allergic reactions. This is very important to keep your child as safe as possible and involved in a healthy environment.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Director's Signature: \_\_\_\_\_ Date: \_\_\_\_\_