

Date: \_\_\_\_\_

Childs Name: \_\_\_\_\_

### ALLERGY

Allergen	Reaction	Treatment	Caused By	Substitution
Specify cause of allergic reaction	Please circle reaction(s) that occur		Please circle how allergy is caused	
	Hives Diarrhea Rash Breathing Problems Vomiting Other: _____		Eating Touching Breathing	
	Hives Diarrhea Rash Breathing Problems Vomiting Other: _____		Eating Touching Breathing	
	Hives Diarrhea Rash Breathing Problems Vomiting Other: _____		Eating Touching Breathing	
	Hives Diarrhea Rash Breathing Problems Vomiting Other: _____		Eating Touching Breathing	

If allergy is to milk/eggs, can child have foods that have milk/eggs baked in or cooked in, such as cakes, cookies, etc.?  
YES NO

If child is allergic to Milk or Lactose Intolerant, can child consume cheese or yogurt?  
Cheese: YES NO Yogurt: YES NO

If insect sting/bite allergy, which type of insect causes the reaction? \_\_\_\_\_

If latex allergy, can child touch things made with latex, such as rubber balls, balloons, etc? \_\_\_\_\_

If allergy to adhesive, please state what is used at home for minor injuries? \_\_\_\_\_

When was your child's last allergic reaction? *(If child has multiple allergies, please provide when last reaction occurred for each allergen; list on back of form if necessary)* \_\_\_\_\_

Did your child get treatment in the Emergency Room? YES NO

What was the treatment? Benadryl Epi-Pen Other: \_\_\_\_\_

Does your child have a current prescription for: Epi-Pen Benadryl/antihistamine

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by Nurse \_\_\_\_\_ Date \_\_\_\_\_