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

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

|  |
| --- |
| What food(s) is your child allergic to? |
| How old was your child when he/she first had a reaction to the above item(s)? |
| Is the allergy ingestion, contact, or both? |
| What kind of reaction occurred at that time? What were the symptoms? Was your child taken to the hospital? |
| What have you done since the first reaction to avoid another reaction? |
| Has your child been prescribed any medications such as Benadryl or Epinephrine to help with the allergy? |
| When was the last time your child had an allergic reaction? |
| Is there any other information you can add regarding your child’s food allergy? |

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