JUMPING JAX KIDS
child care center

Allergy Information Form

Child Information

Last Name_____ First Name_____ Birthday_____

Parent/Guardian Information

Last Name_____ First Name_____ Phone #_____

Last Name_____ First Name_____ Phone #_____

Physician Information

Physician's Name _____Physician's #_____

1) Please indicate items your child has an allergy to:

Peanut/Peanut Products Fish/Shellfish Eggs Milk Gluten

Soy Products Nuts Bee Stings Other _____

2) What things trigger an allergic reaction in your child?

3) What things should be avoided due to the allergy?

4) What are the signs and symptoms of your child's allergic reaction? Be Specific.

5) What treatment or medication does your child have in the event of an allergic reaction? (include doses):

6) What are the procedures for responding if your child has an allergic reaction?

Signature of Parent/Guardian_____ Date_____

Signature of Parent/Guardian_____ Date_____